THE ROLE OF THE VISITING NURSE

AND

THE EMOTIONAL PROBLEMS OF EXPECTANT MOTHERS

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THE ROLE OF THE VISITING NURSE
AND
THE EMOTIONAL PROBLEMS OF EXPECTANT MOTHERS

A Thesis

Presented to

The Faculty of the School of Nursing

Boston University

In Partial Fulfillment of the Requirements for the Degree

Master of Science in Nursing Education

by

Florence Kirstine Salmonsen

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CHAPTER I

INTRODUCTION

Since, at this time, mental illness is the nation's number one health problem, emphasis in psychiatry and mental hygiene has been directed toward the importance of the establishment of good interpersonal relationships which will foster mental health.[1] Studies have shown that the parental attitude toward the pregnancy is significant in the subsequent parent-child relationship, and that this relationship may foster mental health or illness. It is in the antepartal period that the foundations of life are laid, and it has been recognized that good obstetrical care should take cognizance of the emotional as well as the physiological aspects of pregnancy. This study has been undertaken because the visiting nurse, due to the nature of her work, is in a strategic position to aid in recognizing and meeting the emotional aspects which arise during the antepartal period.

What the problem is

What proposals can be offered which will aid the visiting nurse to increase her ability to recognize and deal with the emotional problems presented by patients in the antepartal period?

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[1] Ewing, Oscar. The Nation's Health: A Ten Year Program. Washington, D.C.: United States Government Printing Office, 1948. pp. 115-126.

The purpose of this study is to analyze what the nurse recognizes as emotional problems and how these are handled; to discover if any gaps exist between what this group and what the authorities in the field recognize as emotional problems; and, if any serious omissions are found, to offer proposals which will aid the nurse to more readily recognize and more effectively deal with these emotional aspects.

This problem was approached by considering the following questions:

1. What literature has been presented in this field?
2. What do the obstetricians, psychiatrists and nurse educators feel are the emotional problems during pregnancy which should be recognized and handled?
3. What do the visiting nurses consider as emotional problems of expectant mothers?
4. How are these problems handled? Which are referred to the Mental Hygiene Consultant?
5. If there are problems not being recognized and handled, how can this gap be closed?
6. What conclusions can be drawn?
7. What recommendations can be offered from the study?

<u>What the significant contributions in literature are</u>

Many studies and much valuable material have been presented in this area of the emotional problems of the maternity patient. Four sources were found which are particularly relevant to this study.

Boyd found from his study of mental illness associated with pregnancy that warning signs appear during the gestation period and the best index to these is the attitudes toward the pregnancy.[2] The need for alertness, on the part of the nurse, toward these attitudes becomes apparent.

For the first time, in a text in obstetrical nursing, Zabriskie has included a chapter on the mental hygiene of pregnancy and has also interwoven many psychological principles throughout the text.[3] Kanner presents precisely the theory underlying the attitudes of expectant mothers, including the aspects of good as well as poor adjustment, and offers suggestions as to the nurse's contribution and responsibilities.[4] These are the principles which one would expect to find practiced.

Deutsch has made an extensive study of the psychological aspects of motherhood and has discussed and illustrated the dynamics involved.[5] The illustrations are drawn from problems expressed by such writers of classical fiction as Tolstoy and Balzac and such modern writers as B. Smith, from studies reported by Mead, Sachs, Levy and others, and from actual case

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[2]Boyd, David. "Mental Disorders Associated With Childbearing." American Journal of Obstetrics and Gynecology, 42: 148-163, 335-349, 1942.

[3]Zabriskie, Louise and Eastman, Nicholson. Nurses Handbook of Obstetrics. Philadelphia: J. B. Lippincott Company, 1948. 8th edition. Pp. 716.

[4]Kanner, Leo. "The Mental Hygiene of Pregnancy." As quoted in Zabriskie and Eastman. Ibid., pp. 258-280.

[5]Deutsch, Helene. The Psychology of Women: Motherhood. New York: Grune and Stratton, 1945. Vol. II, Pp. 498.

studies of patients. The factors upon which a harmonious adjustment to pregnancy depend are emotional maturity, sufficient mental and physical health, and fairly favorable environmental conditions.[6] Of the environmental factors, the marital status ranks first, then the social and economic conditions. Since the balance between mental health or illness lies within these factors, it would seem reasonable to expect the nurses to be aware of these.

Piker, using the case study method, studied the causes of mental illness associated with childbearing. In addition to pointing out that the greatest number of mental illnesses were precipitated by the stress and strain of attaining maturity, he identified the premonitory signs as marked irritability, suspiciousness, development of phobias, insomnia, and personality changes.[7] These are the signs which should be watched for and recognized.

The four sources summarized present a reasonably clear picture of those factors toward which the nurse should be alerted for recognition and handling. However, these emotional problems are not necessarily those exclusively associated with pregnancy, but are those which may be found commonly in everyday existence. The present study differs from the foregoing in that it attempts to consider what the nurse, in a selected

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[6]Ibid., p. 153.

[7]Piker, Philip. "Psychoses Complicating Childbearing." American Journal of Obstetrics and Gynecology, 35: 901-909, 1938.

agency, actually does in detecting and handling emotional problems of the pregnant woman. Also, the study attempts to consider whether the nurse detects not only the warning signs but also other factors such as economic and social conditions which, added together, increase the burden of emotional strain.

What the scope of the study is

This study was undertaken in five district offices of an urban visiting nurse association. The administrative staff considered that these would be a fairly representative sampling of the Agency, its responsibilities and functions, its nurses, and its patient load. In each of these five offices, the nurses were asked to select ten antepartal cases which they felt had emotional problems. During a two-month period, an examination was made of the records of these fifty antepartal patients. Then, using the data collected from the records as a guide, interviews were held with ten selected nurses, three obstetricians and three psychiatrists.

What the limitations are

The purpose of the study was to discover whether or not there was evidence that the emotional aspects of nursing the antepartal patient could be strengthened and, if so, by what means. The study, therefore, does not cover all the antepartal patients carried by the Agency. The sampling was limited to 50 patients on the assumption that this number would yield sufficient and reliable information to fulfill the purposes of this study. In the five districts studied, this makes a ratio of one to four antepartal patients carried and, in the

Agency, a ratio of one to fourteen. Since the Agency has other types of responsibilities for the patients, any proposals for the consideration of the emotional aspects of pregnancy will have to be given an appropriate amount of time in an existing in-service plan of education. It is quite evident that, at some future time, a series of case studies of patients and of nurses in the actual situation might reveal other areas which are equally in need of improvement, and would identify those nurses who have particularly deep insight in handling emotional aspects.

What the presentation will be

The philosophy underlying this study will be presented as a criteria to be used in the interpretation of the data and in the formulation of the proposals. In Chapter II, the philosophy underlying the study will be discussed. In Chapter III, the data collected from the literature, from the patient records and from the interviews will be discussed. In Chapter IV, a summary will be made, the conclusions will be drawn, and proposals will be offered.

CHAPTER II

PHILOSOPHY

"No pregnancy, no matter how uncomplicated, is a routine matter."[1] Of this the public health nurses were well aware when the first antepartal visits were started in 1900 by the Instructive Nursing Association of Boston.[2] However, at this time emphasis was on reducing maternal and infant mortality and morbidity. A concentrated effort still needs to be given to this technical area, but not to the exclusion of emotional factors. With the advances made in the psychiatric and mental hygiene fields has come the realization of the need to aid these expectant mothers to adjust to their pregnancy with a minimum of physical discomfort and a maximum of mental health.

Since pregnancy could be one of the periods of psychological stress in a woman's life, it becomes necessary for nurses to have a knowledge of stress symptoms and to deal effectively with emotional problems presented during this period. The visiting nurse on her periodic visits for general health supervision and family health education has an excellent opportunity to observe the patient in her own home; to learn

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[1]Gilbert, Ruth. "Maternity and Mental Hygiene." Public Health Nursing, 28:793, 1936.

[2]Visiting Nurse Association of Boston. "History of the Visiting Nurse Association of Boston." Mimeograph. Boston, 1949. p. 2.

many of the attitudes, hopes, fears and problems; and to aid adjustment. The public health nurse ... "is becoming increasingly important as the detector of incipient of mental disorders and as a contributor to the correction of early manifestations".[3]

But what evidence is there that the nurse assigned to an antepartal patient recognizes and deals with the emotional problems which prevent good adjustment and which, if not alleviated, may lead to more serious disturbances? Mental illness may develop incidiously over a period of years. Many of the symptoms are dismissed or accepted as "normal" with the patient being called depressed, cranky, irritable, suspicious, difficult, anxious, nervous, and many other terms. Too often no attempt has been made to determine the underlying causes of these symptoms which are being manifested. Perhaps the irritating factors may be alleviated by discussion with an understanding, interested nurse, or the problems may require further working through with a social worker or a psychiatrist. It can therefore be assumed that the nurse has a responsibility for aiding the patient to adjust to the pregnancy, to work through problems which arise, and to arrive at a satisfactory solution for comfortable living.

The kind of adjustment made to any situation is a part of the total personality reaction. Many emotional problems met satisfactorily in everyday life may be aggravated by pregnancy.

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[3]Muller, Theresa Grace. The Nature and Direction of Psychiatric Nursing. Philadelphia: J. B. Lippincott Company, 1950. p. 84.

New problems may be precipitated. This may be the first time that an individual in need of help comes in contact with one who is able to offer it, namely the nurse, who has an excellent opportunity to evaluate the existing situation and to guide the patient and her family toward more adequate adjustment and more wholesome attitudes. Therefore, the professional nurse needs to be aware of the emotional aspects of the situation in order to use her nursing skills to the best advantage and to function effectively.

Good nursing care is dependent upon the professional nurse's ability:

1. to ... observe and interpret the physical manifestations of the patient's condition and also the social and environmental factors which may hasten or delay his recovery.

2. to ... apply ... those principles of mental hygiene which make for a better understanding of the psychological factor in illness.

3. to ... cooperate effectively with the family, hospital personnel, and health and social agencies in the interest of patient and community.[4]

"A profession dealing directly with family life considers those factors that most profoundly influence it and promotes and utilizes facilities for improvement of family solidarity."[5] Thus,

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[4]Committee of Curriculum of the National League of Nursing Education. A Curriculum Guide for Schools of Nursing. New York: National League of Nursing Education, 1937. Quoted from an Activity Analysis of Nursing by the Grading Committee. p. 24.

[5]Chayer, Mary Ella. Nursing in Modern Society. New York: Putnam's Sons, 1947. p. 248.

the professional nurse needs not only to be aware of the existing emotional factors but also to know how to deal effectively with those problems, and to cooperate with other available professional and social agencies. Only by teamwork can the nurse act successfully as a promoter of mental health.

The kind of interpersonal relationship established with the patient lays the groundwork for success or failure in dealing with any situation. There are many tools available for aiding the establishment of good rapport: the most important being the personality of the nurse. Several factors have been given for establishing rapport; these are:

1. Characteristics essential in Nurse:

Politeness	Even temper
Tactfulness	Non critical attitude
Friendliness	Poise
Patience	Confidence
Truthfulness	Ability to listen

2. Maintaining an objective attitude
3. Appreciating the individuality of the patient
4. Avoiding arguments with the patient
5. Not deceiving the patient[6]

Basic to the establishment of good rapport is the need of the nurse to understand herself and her reactions. What is there in a particular case that makes it a difficult one to handle? What is there in each personality that increases this difficulty? "Experience with patients who obstruct her efforts can be frustrating to a nurse unless she has the degree of

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[6]Adapted from the Ward Manual, Mosher Memorial, Albany Hospital, Albany, New York.

emotional maturity which enables her to give equally strong support to patients who resist her as to those who give her emotional satisfaction by cooperating and depending upon her."[7]

The nurse needs to have a better understanding of the reasons for the patient's resistance to her teaching of any antepartal regime and of her own reactions to any resistance. For example, how can a person who doesn't accept her pregnancy follow through on diet, rest, personal hygiene and other pertinent suggestions, when consciously or unconsciously she hopes to be able to lose the baby by not following these suggestions? And what about the guilt feelings that come as a result of rejecting the pregnancy? How will this mother treat the child after delivery--by more rejection, or by overprotection as a result of guilt feelings? In these factors of relationships lie the foundation for mental health or illness for both mother and child.

If the nurse is to be a promoter of mental health, and it is in this antepartal period she has so much to offer, she must be aware of attitudes toward the pregnancy and the many factors influencing these attitudes. These may be presented as emotional problems and physical symptoms. If a nurse's contact with a patient is thought of as having either a psychotherapeutic or psychonoxious effect, it then follows that a nurse has a therapeutic or nontherapeutic effect upon the patient.

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[7]Muller. op. cit., p. 215.

If the nurse is to fulfill her role successfully, it would seem that she must become familiar with and reasonably skillful in the art of interviewing and counseling. All too often the nurse has assumed a directive role, deciding what is best for the patient without regard to the patient's wishes or emotional needs. For instance, the nurse, without finding out the reasons for a patient's resistance to antepartal teaching, may continue to impart information, only to have the patient still refuse to follow the prescribed regime. Often the nurse finds it difficult to accept the patient's rejection of the pregnancy either by ignoring the situation or by moralizing and judging the person. It can be seen then, that counseling, a series of direct contacts with an individual, "consists of a definitely structured, permissive relationship which allows the client to gain an understanding of himself to a degree which enables him to take positive steps in the light of his new orientation",[8] is a technic which would enable the nurse to guide the patient toward solving the problems which arise. She should also recognize when the situation requires consultation with the mental hygiene consultant and referral to a social worker or a psychiatrist.

The criteria and frame of reference which underly the interpretation of the data and the presentation of the proposals

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[8] Rogers, Carl. Counseling and Psychotherapy. Boston: Houghton Mifflin Company, 1942. p. 18.

lie in the need for the nurse to have a knowledge of the dynamics of personality adjustment, and particularly of her own self, the importance of the establishment of good interpersonal relationships, and the use of appropriate methods which enable the patient to meet emotional problems.

CHAPTER III

PRESENTATION OF DATA

Currently, considerable attention is being given to the emotional factors relative to the maternity cycle. Observations, experiences and studies have been reported, chiefly from the points of view of obstetricians and psychiatrists. These have implications for the preparation of the nurse for the care of obstetrical patients. This chapter will point up the similarities and differences in points of view of authorities in the field and will compare these with what the nurse, in a given agency, recognizes as emotional problems and how she deals with them.

What the experts say

What the obstetricians say

In a review of the literature by obstetricians, it was noted that generally the physiological and the technical aspects of maternity were emphasized. However, several obstetricians were concerned with the importance of the psychological aspects.

Mengert asserts that no medical field touches psychiatry as closely as obstetrics.[1] In both, personal adjustment is affected by the complexity of the cultural taboos surrounding

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[1] Mengert, William. "Psychotherapy in Obstetrics and Gynecology." Mental Hygiene, 15:299-314, 1931.

sex with the consequent problems of interpersonal relationships. It was suggested that the husband needs to understand not only the physiological but also the psychological changes in his wife. Her reactions might be a quicker, more irritable or a more sluggish, morose and sullen response.

Walser declares that these reactions, also, are the concern of obstetricians, who need to be aware of the patient's emotional needs, to realize that fears can be reduced by establishing good rapport and by answering questions simply and encouragingly, and to recognize the need for psychiatric consultation.[2] He believes that fear builds tension which, in turn, disrupts the process of reproduction in various ways. Also, he concedes as valuable Read's use of suggestion in Teaching the patient to relax physically and mentally so that pain interpretation by the thalmus is less vigorous.

Read indicated that pain is caused by fear which is instilled in women by attitudes of their mothers through subtlety of information or by silence; and by the social expectancy of pain and death which is stressed in newspapers, moving pictures and books.[3] Thus, a state of chronic mental tension is built which frequently causes the minor ailments of pregnancy such as heartburn, tiredness, constipation, salivation, anorexia, and vomiting. However, he believes "no woman should be asked

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[2]Walser, Howard. "Fear, An Important Etiological Factor in Obstetrical Problems." American Journal of Obstetrics and Gynecology, 55:799-805, 1948.

[3]Read, Grantly Dick. Childbirth Without Fear. New York: Harper & Brothers, 1948. Pp. 259.

to bear discomfort greater than she is willing to bear for her child's sake."[4] He stresses the need for education and reassurance so that much of the fear resulting from the unknown may be alleviated.

Read's work influenced the maternity clinic at Yale where, through education and reassurance, as much fear as possible is prevented or allayed. This clinic, under the guidance of Thoms, aims

> ... to help each woman understand how her body, especially her reproductive organs are built, how they function, the changes that occur during pregnancy and labor, what sensations she will have incident to these changes, and finally what she can do at each time to minimize the discomfort and to aid the natural forces of labor.[5]

Thoms, in subscribing to the psychological reactions of women as propounded by Deutsch, stresses that obstetricians should attempt to understand the emotional aspects involved in motherhood.[6]

Although Reid and Cohen disagree with these methods of preparing women for childbirth, they do agree that sound obstetrical care must concern itself with the psychological factors by considering the life, health, emotional welfare and happiness of both mother and child.[7] Reynolds points out

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[4]Ibid., p. 112.

[5]Wyatt, Robert. "A Program of Training for Childbirth." Mimeograph. Yale University School of Medicine, 1950. p. 4.

[6]Thoms, Herbert. Training for Childbirth. New York: McGraw-Hill Book Company, Inc., 1950. pp. xvi / 114.

[7]Reid, Duncan and Cohen, Mandel. "Evaluation of Present Trends in Obstetrics." Journal of the American Medical Association, 142:615-623, 1950.

that some means must be provided for allowing the patient to express feelings.[8] However, because the doctor is parent-like in position of authority, the patient may have conflicts about expressing negative feelings. Ambivalent feelings toward the pregnancy arouse anxiety which, in turn, produce many symptoms such as diarrhea, tachacardia, faintness and pallor.

Hirst and Strousse say that every woman normally shows more anxiety when pregnant and a failure to do so might be considered a deviation from normal.[9] The degree of anxiety presented depends upon the socio-economic status including the relationships with the husband and other members of the family, and the number of previous pregnancies. The expression of phobias and the display of marked anxiety should call for psychiatric attention. The obstetrician, by establishing rapport, individualizing treatment, allowing the patient sufficient time to speak, and by showing sympathy and interest can aid the patient to express emotional difficulties, thus allaying some fears and anxieties.

In general, the foregoing implies the interaction of a variety of factors which affect the well-being and adjustment of the pregnant woman, and these are rooted in the socio-economic status and the attitudinal reactions of the family.

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[8]Reynolds, Philip. "Emotional Factors in Obstetrical Practice." California Medicine, 68:151-153, 1948.

[9]Hirst, John and Strousse, Flora. "The Origin of Emotional Factors in Normal Pregnant Women." American Journal of the Medical Sciences, 196:95-99, 1938.

Although these obstetricians did not indicate the role of the nurse in dealing with emotional problems, it is quite evident that such factors are important to any professional nurse.

In the interviews with three obstetricians, it was found, for the most part, that they agreed with the points in the literature. In addition, they indicated the ways that nurses could help and stressed the following points:

1. Each felt that most women, no matter what the socio-economic condition, are resentful of the pregnancy at first, and indicated that the nurse should establish that kind of relationship which allows the patient to express her feelings.

   Two wished the nurse to emphasize the positive aspects of pregnancy and to avoid such suggestive questions as "Do you have any pain, discomfort?"

   One specified that the nurse should have an attitude of sympathy and understanding and, whenever possible, to have the patient followed throughout the pregnancy by the same nurse.

2. Each pointed out that most women need relevant instruction in anatomy and physiology and the changes that occur during pregnancy, and in what to expect during labor and in the postpartal period.

   Each asserted that the nurse should be well trained in these aspects so that she would be able to answer questions about the course of pregnancy.

3. Each felt that husbands should have similar instruction.

   Two wished combined courses for both husband and wife, stating that the socialization and the discussion of problems in a group is of particular value.

   One found the Red Cross classes helpful to the expectant father and mother.

4. Two indicated that with clinic patients particularly, the nurse needs to be able to recognize and deal with the emotional problems because the clinic doctors usually do not have the time needed to pick up these problems. The nurse should either aid the patient to deal with the problem, or refer the patient to the proper agency or doctor for further therapy.

5. One emphasized that unless emotional needs are met, no amount of teaching will yield desired results.

It is apparent, then, that the nurse needs to be competent not only in the technical but also in the psychological aspects of obstetrical nursing if she is to be effective in aiding the doctor and in carrying out her own responsibilities.

What the psychiatrists say

In a review of the literature by psychiatrists, it was noted that several were concerned with the psychiatric aspects of pregnancy, and stressed the importance of the recognition of the premonitory signs of mental illness.

Cohen points out that "childbearing is a situation with psychiatric aspects" and that much can be done during the antepartal period to detect early signs and symptoms of mental illness and to prevent psychoses by alleviation of stress.[10] For this, it is necessary to know the patient's history and the significance to the patient of the pregnancy and labor. The patient's attitude often reveals the meaning which pregnancy has to her and which dynamically, generally, is fear of death. Opportunity should be given for the patient to express feelings about such things as an unwanted pregnancy, disfigurement, economic worries, interference with a career, fear that the happy sexual and marital adjustment may be affected, or about an unhappy marriage, the husband's attitude, and also, about the reasons for wanting the pregnancy. The initial

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[10] Cohen, Louis. "Psychiatric Aspects of Childbearing." Yale Journal of Biology and Medicine, 16:77, 1943.

consternation, shock and indignation, if continued beyond the first trimester, shows deep-seated rejection which may be expressed by pernicious vomiting, deliberate lack of cooperation in carrying out orders, attempted abortion, or mental disorder. Guilt feelings may be aroused by a pregnancy occurring during the use of contraceptives, or after an unsuccesful abortion. The warning signs and symptoms of mental illness are in personality changes as general discontent, depression, excitement, excessive anxiety, increased tension, apprehension, agitation, irritability, suspiciousness, phobias, insomnia, concern over trivialities, and garrulousness.

Thompson studied the attitudes of a hundred primigravida women and found the majority had enough difficulty in adjustment to warrant consultation with a psychiatrist. He stresses the need for a psychiatrist in a maternity clinic to whom the doctors and nurses could turn for consultation.[11]

Dershimer also maintains that the first pregnancy affords opportunity for giving direction in mental hygiene.[12] He feels that the emotional attitudes and conflicts of civilized women make labor difficult and reports that, by discussing these attitudes, labor was shortened by hours. The most prevalent attitudes with which expectant mothers need help are: euphoria, resentment, and fears: of labor, of loss of freedom, of heredity,

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[11]Thompson, Lloyd. "Attitudes of Primiparae as Observed in a Prenatal Clinic." Mental Hygiene, 26:243-256, 1942.

[12]Dershimer, Frederick. "Influence of Mental Attitudes in Childbearing." American Journal of Obstetrics and Gynecology, 31:444-454, 1936.

of inability to live up to the ideal of motherhood, that marriage may not succeed, and that childbearing is martyrdom. He also feels that all women should be followed through the pregnancy by psychiatrists and that husbands and relatives should be followed and interviewed in the home by social workers. He contends that:

> the one thing that cures feelings of insecurity in individuals has been any proper, fair, legitimate means of getting them to realize that no one but themselves could solve their problems for them. Then, second, to get them to settle down and meet their own responsibilities face to face and solve them for themselves, and by their own methods as best they could.[13]

Hall and Mohr also studied the attitudes of sixty-six women expecting the first "live child". They report that the majority of pregnancies were not planned. The reasons for difficult or impossible acceptance of the pregnancy

were noted as follows:

Financial	28
Fears concerning heredity	16
Superstitions and fear of 'marking'	13
Marital conflict	13
Fears of pregnancy and delivery	7
Illegitimacy, bigamous marriage or forced marriage	6
Racial or religious conflict	5
Physical complaints	5
Parental disapproval	4
Dislike of children	2
Fear of effect of birth control	2[14]

From psychiatric consultations and intensive study of maladjusted pregnant women, Henry also discovered that the

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[13]Dershimer, Frederick. "Constructing the Forces in the Job." Mental Hygiene, 32:379-380, 1948.

[14]Hall, Dorothy and Mohr, George. "Prenatal Attitudes of Primiparae." Mental Hygiene, 25:231, 1933.

majority of pregnancies were accidental and summarizes the nine most prevalent problems which made acceptance of pregnancy difficult.[15] These are:

1. Marital difficulty
2. Primary interest in own self
3. Husband is a father substitute
4. Feeling of not being physically attractive during pregnancy
5. Economic stress
6. Feelings of disgust
7. Feeling that pregnancy is just another stress
8. Dominant masculine characteristics
9. Need to compete with children for affection and good looks.

It can be noted that only two problems, financial and marital difficulties, are the same as those found by Hall and Mohr. Moreover, Henry's study seems more concerned with the dynamic aspects rather than the more superficial manifestations. Henry reiterates that the personal problems of the pregnant woman, her physiological and emotional fitness for motherhood, do not receive sufficient attention from the doctor who is primarily interested in obtaining a successful delivery. He warns that behavior and emotional reactions must be watched and not just the words spoken.

Boyd sketches the history of mental disorders associated with childbearing. No evidence was found of endocrine changes during the pregnancy significant enough to produce puerperal mental disorders. The studies made to find exact incidence show great variety and discrepancy; and these are said to be

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[15]Henry, George. "Mental Hygiene During Pregnancy." Preventative Medicine, 7:209-216, 1937.

the result of the socio-economic system, wars, health standards and the illegitimacy rate of the community. He found that most doctors agree that psychological factors are more important than physiological aspects in causing puerperal mental illness and stresses ... "childbearing constitutes a difficult life situation which imposes physical, physiologic, psychologic and social stresses upon the pregnant woman".[16] If mental disorders are to be better understood, they should be thought of ... "as inferior and maladjusted patterns of reaction designed to meet biological, social and personal problems confronting the individual. Different individuals possess varied quantities of psychic reserve with which to meet various social, physical and psychologic stress".[17] Then it becomes important to answer this question, ... "is the patient's psychic reserve (heredity, constitution, training, personal psychologic organization) sufficient to resist the factors producing mental disorders (toxicity, endocrine imbalance, psychologic conflicts engendered by pregnancy)?" It can then be understood that ... "a patient of poor personality organization may become mentally ill in spite of excellent physical health and few apparent socio-economic-psychic problems, while another individual of more asthenic personality structure passes mentally unscathed through the most adverse and complicated circumstances of

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[16]Boyd, David. "Mental Disorders Associated with Childbearing." American Journal of Obstetrics and Gynecology, 42:149, 1942.

[17]Ibid., p. 149.

childbirth".[18] Studies reveal that warning signs appear during the gestational period and the best index of these is the attitude toward the pregnancy. These are: rejection expressed in an attempt to produce abortion, weeping and ranting against husband, or more subtly as an irritable reference on the unenviable position of women and particularly herself; and unwholesome attitudes and expressions of irritability, temper tantrums, tension over trivialities, apprehension and panic to flightiness, disconnection of speech and thought, and wide emotional swings.[19]

That signs of low psychic resistance exist which might be recognized before mental illness in a catastrophic form becomes evident is the conclusion of Zilboorg.[20] He says these signs are found in the psychosexual development of the individual, the interest in the opposite sex, the attitude toward the partner, any aloofness or shyness toward men, a courtship lasting several years, a domineering mother, any compulsion and persistent frigidity.

Smalldon finds approximately the same results as Zilboorg but differs in statistics of occurrences of kinds of mental disorders.[21] Both stress hostility expressed toward the child

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[18]Ibid., p. 152.

[19]Ibid., p. 346.

[20]Zilboorg, Gregory. "Malignant Psychoses Related to Childbirth." American Journal of Obstetrics and Gynecology, 15:145-158, 1928.

[21]Smalldon, John. "A Survey of Mental Illnesses Associated with Pregnancy and Childbirth." American Journal of Psychiatry, 97:80-98, 1940.

which Smalldon says breaks through in a fear of something happening to the child.

Piker's study of 770 cases finds that 24 per cent became ill during gestation and 76 per cent in the postpartal period, of which 4 per cent were during lactation.[22] Of these, the largest number were precipitated by the stresses and strains of attaining maturity. Signs of beginning illness were marked irritability, suspiciousness, development of phobias, insomnia, and personality changes.

Deutsch shows the dynamics underlying the reactions to motherhood such as:

1. "... deep lying fear that the ego will be destroyed in favor of the child and that the new life flourishes on either the ruin or the cost of the mother's life."[23]
2. The duality of attitudes--physically with consciousness of a new being that is connected and identical with her, and both physically and psychically that her body is in service of something not herself, and that she receives nothing, only gives. This leads to two reactions: "I am the whole world", which gives rise to feelings of life, love, pride and happiness; and "I am nothing", which gives feelings of depression, shame, hatred, destruction, and death--this crystallizes in "I shall die in childbirth".

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[22]Piker. op. cit., pp. 901-909.

[23]Deutsch. op. cit., pp. 43-44.

3. The fear that giving life is the losing of life, for separation by birth is death--that is, the woman loses part of her self since the child is part of her ego.[24]

However, she stresses that this fear, separation is death, is greatly overshadowed and is finally banished by the happiness which comes from a rapid reunion with the baby. Every effort must be made to preserve this degree of gratification.

Fears may be partly justified, contends Menninger, but many times they are unjustifiably magnified or may be a rationalization of a deeper fear.[25] Timing, financial insecurity, employment of the mother, insecurity of marriage, using the pregnancy to hold the husband, husbands who are psychologically immature, antagonistic and hostile attitudes, and social pressures, all influence the reaction to the pregnancy.

Although none of this material was written specifically for the nurse, it offers a consistent frame of reference from which the nurse can gain a deeper understanding of the dynamics underlying many of the reactions shown and symptoms produced; gain a deeper appreciation for the need of awareness of warning signs and symptoms of emotional maladjustment; and gain a basis upon which she may act more effectively in aiding the patient's adjustment to the pregnancy. It is quite evident that these points must be taken into consideration in the preparation of the nurse.

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[24]Ibid., p. 159.

[25]Menninger, William. "The Emotional Factors of Pregnancy." Bulletin of the Menninger Clinic, 7:15-24, 1943.

Several psychiatrists have become concerned with the nurse's role in dealing with emotional problems and particularly those during pregnancy.

Mann stresses the importance of establishing satisfactory interpersonal relationships and that the "alert and progressive nurse must be aware of ... emotional problems if she is to make full and most significant use of her nursing skills".[26] "A knowledge of some of the ways of meeting these problems from the standpoint of mental health would aid a nurse in the routine performance of her duties to promote better mental health of mothers and children."[27] Since the pregnant woman runs a gamut of feelings from happiness, joy, and fulfillment, physical well being to physical misery, fears of various kinds and resentment, she needs to talk out her problems with someone who will not judge the situation as right or wrong. (The nurse needs to re-examine her own feelings, to lend herself to the formation of constructive nurse-patient relationships, not to stir up emotions by probing for a motive but to have an attitude of assurance and reassurance, and to realize there are some patients who cannot be helped.) She needs to know the technics of interviewing and to know why certain cases are difficult to handle and what, in her own personality, increases this difficulty. Good supervision and in-service programs are

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[26]Mann, James. "Human Relations in Public Health Nursing." Public Health Nursing, 40:583, 1948.

[27]Zimmerman, Kent. "The Public Health Nurse and the Emotions of Pregnancy." Public Health Nursing, 39:63, 1947.

more effective than lectures for aiding the nurse to re-examine how she feels about patients. A mental hygiene consultant to whom the nurse can turn for guidance and clarification should be available.

Nurses should also know the psychological dynamic concept of development and should try to understand and cope with patients rather than dismissing some as nuisances,[28] says Jones. The most important factors to the course of pregnancy and delivery are the attitudes toward the fetus and childbearing, and the socio-economic status. Women fear deeply that they will be torn open and damaged internally. This fear may be developed first, by knowledge that they are endowed with an "open place", second, by menstruation, and last, by childbirth itself. The unconscious ideas of hatred, guilt or fear concerning the fetus may yield symptoms such as expulsive movements (threatened abortion), constipation, pernicious vomiting, and fears of birthmarks and deformities.

Relief from distress may follow if a patient has been allowed to express her emotional problems freely with a sympathetic objective listener. Some fears may be alleviated by this sympathetic listening and by education and re-education.[29] The length of time of pregnancy allows the nurse

> ... ample opportunity to become acquainted with the mother's personality, the circumstances of her environment, her attitudes and opinions, her outlook

[28]Jones, Ernest. "Psychology and Childbirth." Lancet, 242:695-696, 1942.

[29]Kohl, Richard. "The Psychiatric Aspects of Obstetric Nursing." American Journal of Nursing, 48:422-425, 1948.

> on life and the degree of her emotional stability. It is not too difficult to sense and spot genuine happiness over the pregnancy, resentful rebellion against it, stunned acceptance of the conception as an unexpected decree of destiny, or disturbing apprehension regarding the outcome.[30]

Kanner discusses the dynamics underlying the reactions of pregnancy and states that the nurse's contribution lies in her ability to understand, listen and guide. She needs to have adequate information and be able to impart it to the patient, and to realize that some questions indicate presence of apprehension and desire for clarification. By allowing the patient to verbalize feelings, asking questions as "what makes you feel this way--why does this bother you?", the nurse can aid the patient to better understand her feelings and problems.

For guiding the patient, the nurse needs to be able to explain directions to make them acceptable, to know community agencies which can be used as resources, and to have a good knowledge of obstetrics so that she can aid the patient to talk out fears and to prepare for the new child. Although there is little the nurse can do about rejection which has deep rooted unconscious conflicts, she can aid the release of some of the anxiety and guilt feelings by listening.[31]

> Listening to people should be one of the easiest, but actually is one of the most difficult things to do. The need to impress our own ideas and methods on others is great. Allowing people to talk enables them not only to let us know how they feel, but also gives them an opportunity to get rid of a great deal of

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[30]Kanner. op. cit., p. 259.

[31]Kohl. op. cit., pp. 422-425.

> feeling which bothers them. By listening to people we get to know them and much more can be accomplished if there is an understanding between people .... (The pregnant woman) needs an opportunity to talk to some sympathetic, understanding person who has had sufficient professional training so that she not only can listen, but also can give support and reassurance. Here the nurse has an advantage because the traditional role of nurse is that of helping other people. She is accepted in that role.[32]

The foregoing alleges the interaction of the inner and outer world reactions of the pregnant woman and specifically indicates those areas where the nurse needs preparation in order to successfully fulfill her role of assisting the doctor in the welfare of the patient and in meeting the emotional needs of the patient.

Interviews were held with three psychiatrists, who agreed with the material presented in the literature and stressed the following:

1. Each propounded that the nurse needs to be able to establish satisfactory interpersonal relationships and to allow time which will permit the patient to express feelings and problems.

2. Each specified that the nurse needs to be educated in the psychological aspects, particularly the dynamics of personality development, as well as in the organic and technical aspects.

3. Each maintained that the nurse should keep to the reality situations, allow expression of negative feelings, and stress the positive aspects.

4. Two declared that the nurse needs to be able to recognize how much anxiety is provoked by the situation and refer the patient to a psychiatrist if anxiety becomes greatly increased. Any increased anxiety should be referred to a social worker and a doctor.

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[32]Hewitt, Robert. "Mental Health in Nursing." Public Health Nursing, 42:255 / 257, 1950.

5. Two reiterated that husbands should be considered and included in plans and instructions.

6. One mentioned that the nurse needs to understand that all illnesses carry emotional problems, threats and worries, which should be detected and met.

7. One pointed out that the visit should not be confined to what the nurse feels is important for teaching but rather to the patient's feelings and interests.

Again it becomes evident that the nurse needs preparation in the physiological and psychological aspects, and interviewing technics, if she is to be competent in aiding the doctor and in carrying out her responsibilities.

What the nurse educators say

Emphasis has been on the physiological and technical aspects of obstetrical nursing; however, there is increasing concern about the psychological aspects of pregnancy. In the maternity nursing texts there has been a noticeable absence of emphasis on the patient as a person and on the need for the recognition of those problems and feelings which make good adjustment to pregnancy difficult.

Zabriskie has included a chapter, written by Kanner, on mental hygiene.[33] Moreover, throughout the text many of the emotional problems encountered by pregnant women are discussed with suggestions as to the instructions the nurse can give to allay fears and anxiety.

> In addition to detailed supervision (in regard to hygiene of pregnancy), the patient needs an explanation of the changes that are taking place

[33]Zabriskie. op. cit., pp. 258-280.

> within her body. This intelligent instruction will give her greater reassurance and self-confidence. An understanding and sympathetic attitude will do much to buoy the patient's morale.[34]

Woodward and Gardner also have a chapter on the "Mental Hygiene of the Pregnant Woman", in which some reasons for a rebellion against pregnancy are discussed and a few suggestions for the nurse's handling of the problems are given.[35] Throughout the text, however, only minor attention is given to the psychological needs of the maternity patient. The other texts barely mention attitudes and reactions to pregnancy.

Although few articles on the emotional aspects of pregnancy have been written in the nursing journals by nurses, with the newer trends in maternity, more stress is being placed on emotional reactions and more material is being contributed.

In a series of three articles, Gilbert discusses why the nurse needs to have a mental hygiene point of view toward the patient's needs, how some problems are manifest, and gives practical suggestions for dealing with them.[36] She calls attention to the nurse's need to strive for an unhasty observant way of working which will allow for thinking about what the behavior of the patient really means and how the nurse

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[34]Ibid., p. 162.

[35]Woodward, Henry and Gardner, Bernice. Obstetric Management and Nursing. Philadelphia: Davis Company, 1946. 3rd ed. pp. 153-161, Chapter XIV.

[36]Gilbert. op. cit., 28:793-798; 29:16-21, 88-94; 1936 / 1937.

relates to the situation. The significance of attitude therapy is propounded.[37] She warns that teaching becomes useless unless an individual's different needs are met and problems accepted without judging right or wrong or showing surprise. Opinions which make health education useless may be changed by understanding the problems as seen by the patient and by explaining to the patient what to expect and what is happening.[38] "Situations which cause tensions, antagonisms and fear must be removed before we can achieve the ultimate purpose for which obstetrics exists."[39] Security is obtained through education and support given to the mother by the family, friends and professional workers. For too long maternity care has been mechanized and the patient considered just a "pregnant uterus".[40] Since the advent of natural childbirth technics, the patient again becomes an important individual who, with her husband, is taught how babies are conceived, developed and born; who is taught how to relax and prepare for labor; who is given support and encouragement during labor; and later guidance during the postpartal period. Classes are described in which expectant mothers are aided to gain security by the

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[37]Gilbert, Ruth. The Public Health Nurse and Her Patient. New York: Commonwealth Fund, 1940. pp. 206-243.

[38]Maternity Center Association. "Motivation the Key to Health Education." Briefs, XIII, No. 2:13-16, 1949.

[39]Corbin, Hazel. "Emotional Aspects of Maternity Care." American Journal of Nursing, 48:20-22, 1948.

[40]Corbin, Hazel. "Natural Childbirth." American Journal of Nursing, 49:660-662, 1949.

verbalization of anxieties and objective explanations; and exemplify the value of the psychiatrically prepared nurse in mental health education.[41] Also,

> A person experienced in psychiatry will distinguish negative behavior characteristics as symptoms of mental disorder, whereas another person is likely to use such designations as fussy, difficult, morose, irritable and innumerable others .... Understanding the behavior reactions common to mental illness leads to an appreciation that these are not readily distinguished from similar normal reactions based upon real causes, such as depression from the loss of a beloved one or fear of a real threat.[42]

Although there seems to be no general accord as to what constitutes psychiatric help ... "discrimination of conditions considered benign may well be left to those appropriately prepared, who will use available means of verifying doubtful ones".[43]

> Though there are no limitations to the possibilities for individual emotional disturbances during pregnancy, some physiologic and psychological manifestations are rather general, and their identification and relevant modification are important to mental health and the prevention of mental illness concomitant with the period .... In addition to relevant physical hygiene, the nurse who can listen to the patient with interest tends to establish rapport which eventually causes the patient to reciprocate with interest in what the nurse is able to contribute to her well being. Without this relationship, the nurse's words fall on sterile ground.[44]

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[41] Shalit, Pearl. "The Psychiatric Nurse in a Community Mental Health Program." American Journal of Psychiatry, 105:377-379, 1948.

[42] Muller. op. cit., pp. 70 ⁄ 214.

[43] Ibid., p. 85.

[44] Ibid., p. 216.

> The personal bond which inevitably develops between a worker and a patient is basic to therapy, but the worker in each group needs to understand himself and his own limits, defined not only in accordance with his specific professional group but also with the community organization of which he is a member.[45]

Thus, it is evident that most nurse educators are becoming concerned with the psychological aspects of patient care and that there is still much work to be done in this area.

What the comparison of these authorities is

What the obstetricians, psychiatrists, and nurse educators say regarding the emotional problems of pregnancy and the nurse's role in this area, may be noted.

These are some of the agreements:

1. Psychiatry and obstetrics are closely related.
2. A psychiatrist, mental hygiene consultant, or psychiatric social worker should be available for consultation.
3. There is need for awareness of the patient's emotional problems and state of tension, and what the pregnancy means to the patient.
4. Fears, anxieties and tensions are the basis of many physical symptoms and must be dealt with.
5. The kind of interpersonal relationship established should allow the patient freedom for expression of ideas and feelings.
6. The factors for establishing rapport are noted as individualizing treatment, allowing free expression of ideas and feelings, an understanding, sympathetic attitude, plus a sound knowledge of obstetrics.
7. Unless emotional needs are met and good rapport established, all teaching becomes sterile.
8. The family, particularly the father, must be considered.

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[45] Ibid., p. 97.

9. The nurse needs to be well prepared not only in the technics of obstetrical nursing but also in the psychological aspects.

10. Although some problems present an insoluble dilemma, the patient may be helped through discussion to achieve a more wholesome attitude toward the problem.

These are some of the differences:

1. The obstetricians lay emphasis on didatic teaching as a means of reducing fears, tensions and anxieties, particularly since the advent of natural childbirth.

2. The psychiatrists lay emphasis on:

   a. The dynamics underlying the fears, tensions, and anxieties. As Kanner says "Read did not pay sufficient attention to the basic mechanisms of the emotional conflicts which are at the bottom of a mother's tensions and fears".[46]

   b. The importance of the patient's attitude, which may indicate the warning signs of beginning mental illness.

   c. The importance of knowledge of the psychodynamics of development.

   d. The need for the nurse to have a knowledge of the technics of interviewing.

3. The nurse educators indicate that:

   a. The obstetrical nurses stress knowledge of normal obstetrics as a means of allaying the fears, tensions and anxieties.

   b. Both public health and psychiatric nurses stress the importance of allowing the patient to express feelings and problems, and of establishing good rapport.

   c. The psychiatric nurses stress the importance of early recognition of signs of emotional maladjustment; and the need for awareness of the nurse's role in interpersonal relations.

With increasing environmental demands, worries, anxieties, and resultant disharmony and disturbance of good interpersonal

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[46]Kanner. op. cit., p. 270.

relationships, a situation arises which disrupts satisfactory social and emotional development of both the parents and the children and fosters mental illness. The nurse has an important role to play in the recognition of early behavior deviations and emotional problems and in the helping with the alleviation of stress symptoms. The need of education and experience in psychological aspects of care can no longer be ignored.

What a given public health nursing agency does

An understanding of the total situation is essential for an interpretation of the findings. The chief sources of information are the agency policies, the patient records, and the interviews with selected nurses and the mental hygiene consultant. It becomes obvious that the next step is to examine what is being done in a given agency.

What the Agency studied is like

This Agency, partially supported by the Community Chest, is a voluntary visiting nurse association in a large city which ... "maintains 12 district offices ... and a staff of 100 graduate registered nurses trained in public health nursing and qualified workers in the field of nutrition, physical therapy and mental health".[47] The Association also offers a training program for students of nursing, nutrition, and physiotherapy. "The aim of the association is to nurse the

[47] Visiting Nurse Association of Boston. "Information for Physicians." July 1949. p. 3.

sick in their homes and to instruct the sick and the well in ways of attaining and preserving health."[48] The Association subscribes to a generalized practice.

The Agency maintains a staff education program which is organized to orient the new nurse to the Agency and to provide continued professional growth through in-service education.

The orientation program consists of a series of lectures and discussion covering policies, procedures, and technics of the Agency and specific orientation to the district. The in-service education is a continuous process planned on a yearly basis and is the shared responsibility of all staff members. Each district office plans a maximum of six one-hour sessions, and the administration plans four general staff meetings to carry out the aims of the Agency:

1. To keep staff members informed regarding new developments and trends in public health nursing and allied fields.

2. To afford experience in group leadership, organization and group discussion methods.

3. To provide one medium through which the consultant staff may relate the special implications of their service to demonstrated staff needs.

4. To provide opportunity for joint study of agency tools and community resources and ways in which they may be utilized for improved patient and family health service.

5. To foster closer working relationships between staff members of all levels and services and with other agencies.[49]

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[48] Ibid., p. 3.

[49] Visiting Nurse Association of Boston. "Formal Staff Education Program." Typed Report, 1949.

In addition to this planned time, short informal conferences may be held at the discretion of the district supervisor. During the year 1948-49, a total of 147 hours and 30 minutes was spent on staff education by the 12 districts; a total of 70 hours was spent by the 5 offices included in this study. In the districts studied, 9 hours and 32 minutes were spent on the maternity program, one hour of this centered on the mental aspects of pregnancy. In the other districts, 3 hours and 30 minutes were spent on the maternity program, 5 hours and 15 minutes were spent on the emotional aspects of other conditions. One of the large staff meetings had as the topic of presentation, "Mental Aspects of Diseases".[50]

The mental hygiene program was introduced in 1926.[51] The consultant, by individual or group conferences, assists the nurse: to become skilled in interpersonal relationships, to guide parents in meeting the normal difficulties which arise in the training of children, and to guide those with more serious deviations to a doctor or clinic. She also acts as a liaison between the nurse and the agency to which the patient is referred, by discussing the cases with the doctor and, in light of this, aiding the nurse prepare plans for handling the case. The nurse may handle: simple feeding, elimination and sleeping problems; thumb sucking and negativism in tiny children; antepartal worries and fears which are more or less

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[50] Visiting Nurse Association of Boston. "Report of Staff Education Program." Assembled data. September 1948-May 1949.

[51] Visiting Nurse Association of Boston. "Office Manual." Division: Mental Health. Mimeograph 1949-50. pp. 1-5.

natural when based on lack of knowledge, inexperience, and social misunderstandings; and simple adult problems residing in strained family relations, financial and social difficulties. The nurse confers with the district supervisor before referring to the consultant any patients who show personality changes or who are mentally ill or deficient; and any cases of marital, financial, social, and emotional difficulties which indicate need for intense family service. She then carries out the suggestions and recommendations. The district supervisor and mental health consultant are available for consultation whenever the nurse feels the need for help.

The maternity service gives care and instructions without charge to expectant mothers either in private consultation in their homes or in classes held weekly in the district offices. Expectant mothers are taught how to care for themselves and how to prepare for the new baby. In the postpartal period, care and instruction is given to the mother which includes care of the newborn and, when indicated, demonstration baby baths and supervision of formula preparation. The consultants in physiotherapy, nutrition and mental hygiene are available to assist with guidance in the correction of physical defects, in special health problems, and in everyday family health living.

The demonstration, lecture and discussion meetings at Mothers' Club, planned by the nurse, nutritionist and the Maternity Committee, include such topics as mothers' health and diet during pregnancy, anatomy and physiology pertaining

to reproduction, preparation for confinement, baby's layette and bath, postpartal care and health, and habit training for the baby. The aim of the Mothers' Club, through group discussion, demonstration and lectures, is to aid the expectant mother's adjustment to pregnancy and maintenance of the maximum possible physical and mental health. With the exchange of ideas in group discussions, the mothers are given the opportunity to express fears, worries, uncomfortable feelings and physical discomforts. From this they tend to realize that many of the same feelings are being experienced by others. The mothers who attend the club are visited at least once in their own home. However, only a small number of pregnant women attend the club; the majority are handled on an individual basis.

Each nurse is responsible for organizing the work in her own district. For the maternity cases, she plans her visits according to patient needs. These are usually once a month and arranged to fall halfway between clinic visits. During these visits, she checks the blood pressure, urine, and general condition and progress, noting carefully any signs of complications, discussing any problems that arise, and teaching the usual antepartal regime. The usual time allotted for a visit is 45-60 minutes, but more may be spent as needed.

What the setting of the study is

Five districts of this urban visiting nurse association were selected on the assumption that they were representative of all the districts in the Agency; and would, therefore,

provide the full range of cultural, socio-economic differences. Each of the 5 districts was asked to choose from their case load a total of 10 cases in which the nurses felt the maternity patients had emotional problems of any kind. The nurses seemed unsure about the patients who had emotional problems and several felt that these were only present in those women who were under psychiatric care or whose behavior was obviously abnormal. It was explained that any patient was acceptable who seemed to be having difficulty or with whom the nurse was having difficulty. It was easier then for the nurses to choose the records. As many nurses as necessary contributed to make the arbitrary number of 10 cases from each district complete. No attempt was made to determine the extent to which emotional problems existed in the remaining antepartal case load.

It is estimated that, in 1949-50, 5,509 antepartal cases were carried. The 50 cases chosen represent one out of every four antepartal patients active in these 5 districts at the time of the study. Since the purpose of this study is to discover whether or not there is evidence that the emotional aspects of nursing the antepartal patients need to be strengthened, it is assumed that one in four cases would give a reasonably reliable view of the situation.

What the group of patients studied is like

Although a small number of antepartal patients carried by the Agency are referred by private doctors, the patient herself, her friends, other agencies in the city, or by the nurse, the majority are referred by the clinics. All of the

patients in this study were referred from the clinics. A study done by Donahoe on 302 pregnant women, showing definite mental symptoms, shows that

> Problems in the professional group and the problems in the general run of patients ... were so similar that we feel the fact that pregnancy, in whatever group (wealthy to very poor) carries along with it certain psychic situations that should not be ignored.[52]

The records of each of the 50 antepartal patients selected were examined for identifying data. It was found that the age ranged from 16 to 41 years (Fig. 1). The gravida of each patient varied from the first to the ninth with the majority having three or less pregnancies (Fig. 2). In Figure 3 it can be seen, the majority of patients with only one pregnancy are 24 years old or less; the majority of patients with 5 or more pregnancies are 28 to 33 years of age. Of the group 31 years of age and above, there were none with only one pregnancy.

The time at which these patients were admitted to the antepartal service for care varies from the first month of pregnancy to the minth (Fig. 4). The greatest single number were admitted in the fourth month. Only one-fourth of the group were admitted in the first trimester; one-half were admitted in the second trimester; and one-fourth had no medical care until the last trimester. The specific reason for failure to seek medical supervision earlier was not reported on the records.

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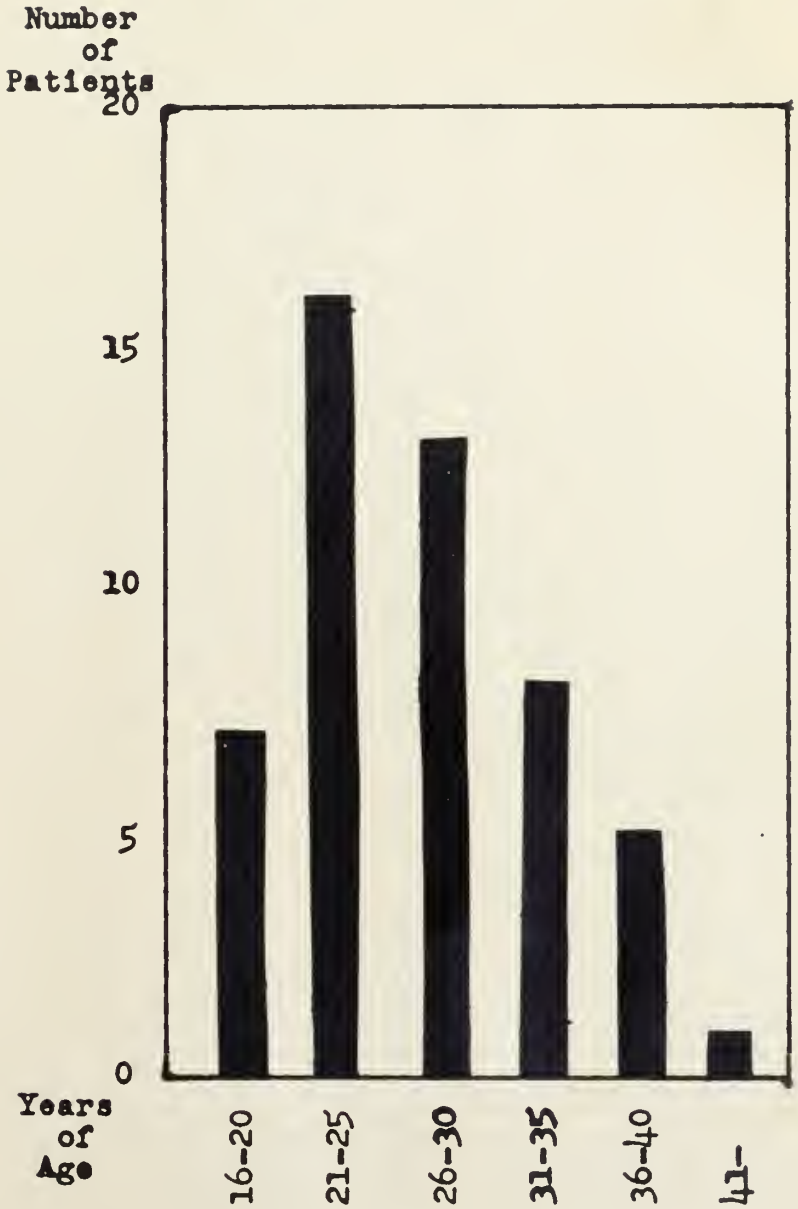
[52]Donahoe, Marie. "Mental Health and Pregnancy." Unpublished, Visiting Nurse Association of Boston, 1930. p. 15.

Figure 1

Years of Age of 50 Antepartal Patients Studied in a Selected Visiting Nurse Association

October 1 - December 31, 1949

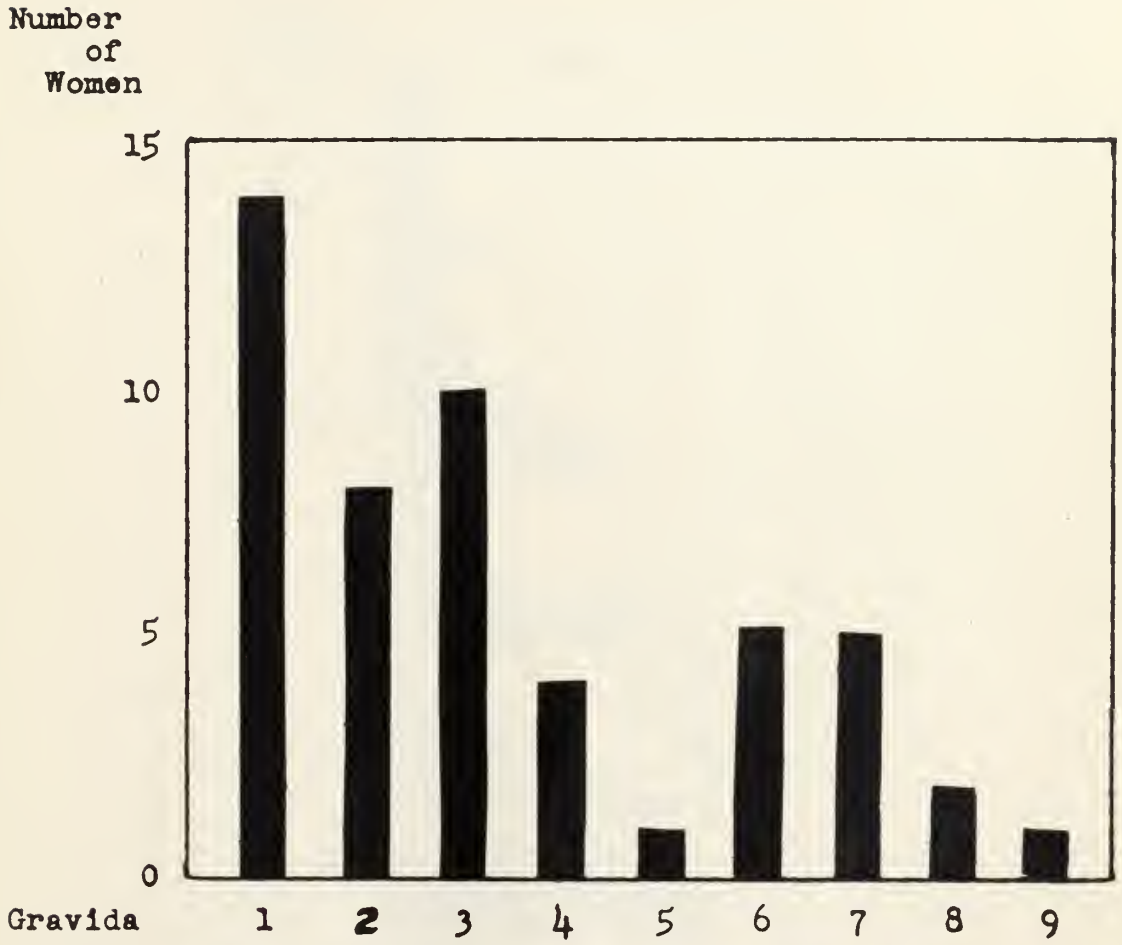


Source: Compiled from patient records on file with the Association, and represents ½ out of 4 antepartal patients served by the 5 Districts

Figure 2

Gravida of Each of the 50 Antepartal Patients Studied in a Selected Visiting Nurse Association

October 1 - December 31, 1949

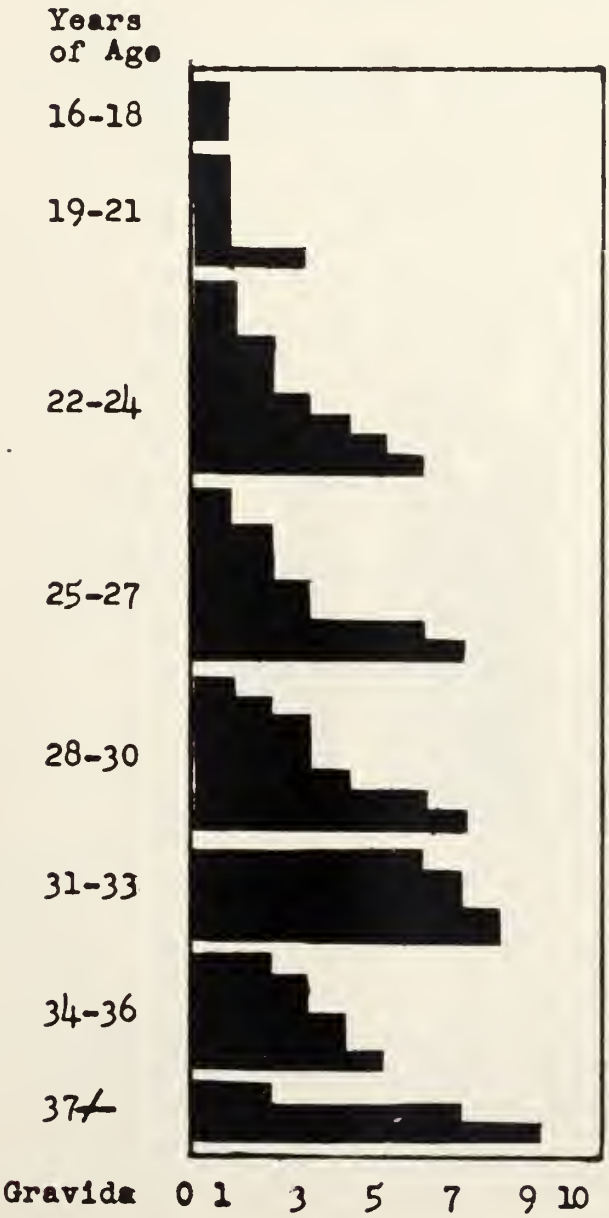


Source: Compiled from patient records on file with the Association, and represents 1 out of 4 antepartal patients served by the 5 Districts

Figure 3

Years of Age and Gravida
of Each of the 50 Antepartal Patients Studied
in a Selected Visiting Nurse Association

October 1 - December 31, 1949

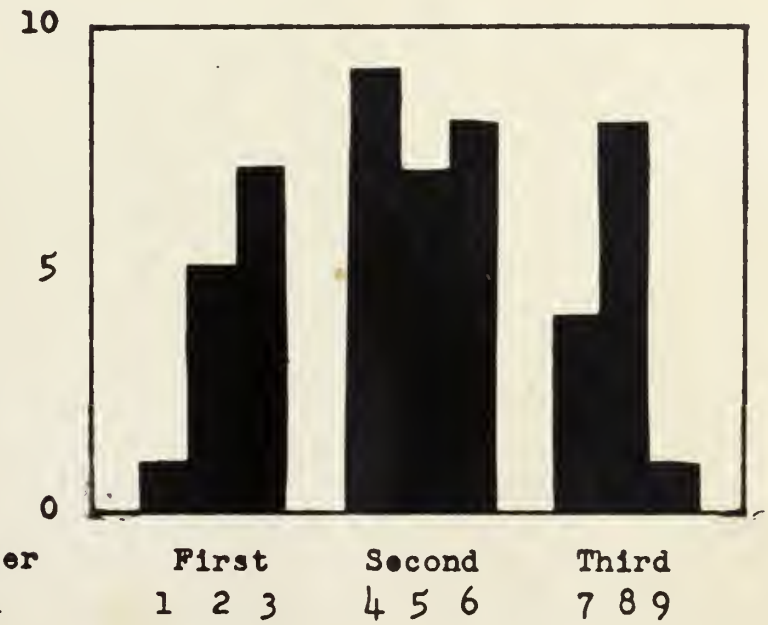


Source: Compiled from patient records on file with the Association, and represents 1 out of 4 antepartal patients served by the 5 Districts

Figure 4

Month of Pregnancy during which
Each of the 50 Antepartal Patients was Admitted
to a selected Visiting Nurse Association

October 1 - December 31, 1949



Source: Compiled from patient records on file with the Association, and represents 1 out of 4 antepartal patients served by the 5 Districts

An attempt was made to ascertain whether or not any relation existed between age and month admitted for care. As can be seen, there is no correlation for these 50 women between age and the time the patient comes for care (Fig. 5). Likewise an attempt was made to correlate gravida and month admitted for care. Figure 6 shows again that no conclusions can be drawn, although the largest number of primigravida women are under medical supervision by the third or fourth month. The variables among the age and gravidas show these factors not to be significant for this group.

When the records were examined in relation to religion, it was found one-half of the group were Catholic and approximately one-third Protestant (Fig. 7). Five were mixed marriages of two Catholic-Jewish, and three Catholic-Protestant. Three fell into the religion of the Greek, Chinese and Syrian faiths. In two cases the religion was not given and, on checking, was not verified. There were no families of the Jewish faith in the study.

What problems the patients presented

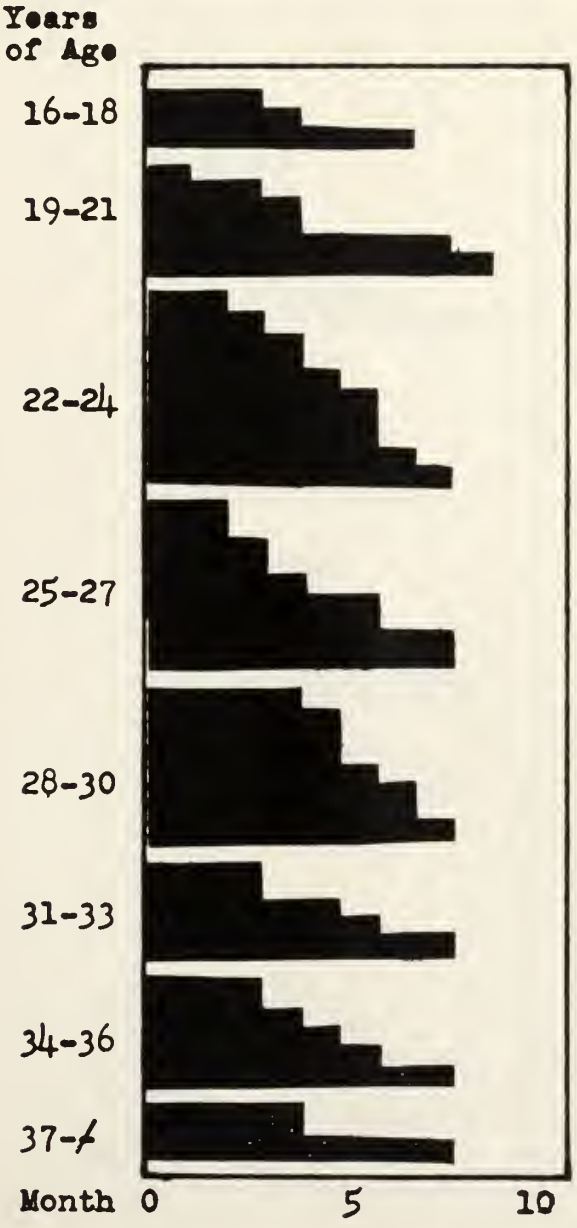
The records of each patient were studied to ascertain the types of emotional problems recognized and recorded. Each record contained the family folder, social data sheet and an antepartal record. As these were studied, the pertinent problems relating to emotional aspects were selected and tabulated.

Table 1 may be used to show the number of times factors which affect adjustment appeared on the records. To assure clarity and ease of handling, the data were grouped into three

Figure 5

Years of Age in terms of the Month
Each of the 50 Antepartal Patients was Admitted
to a Selected Visiting Nurse Association

October 1 - December 31, 1949

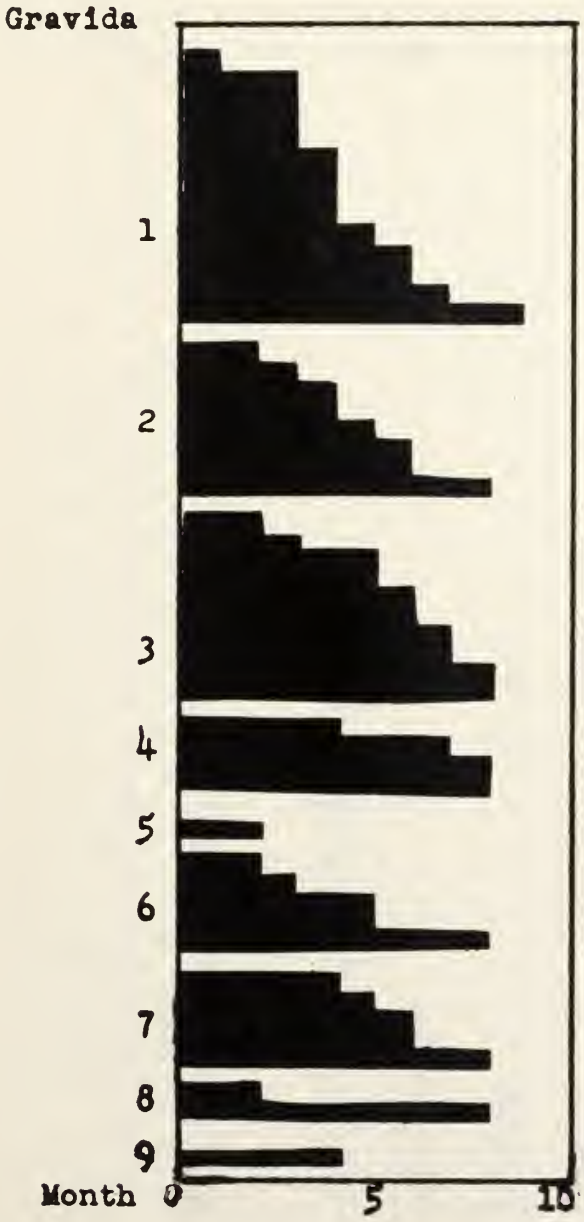


Source: Compiled from patient records on file with the Association, and represents 1 out of 4 antepartal patients served by the 5 Districts

Figure 6

Gravida in terms of the Month
Each of the 50 Antepartal Patients was Admitted
to a Selected Visiting Nurse Association

October 1 - December 31, 1949

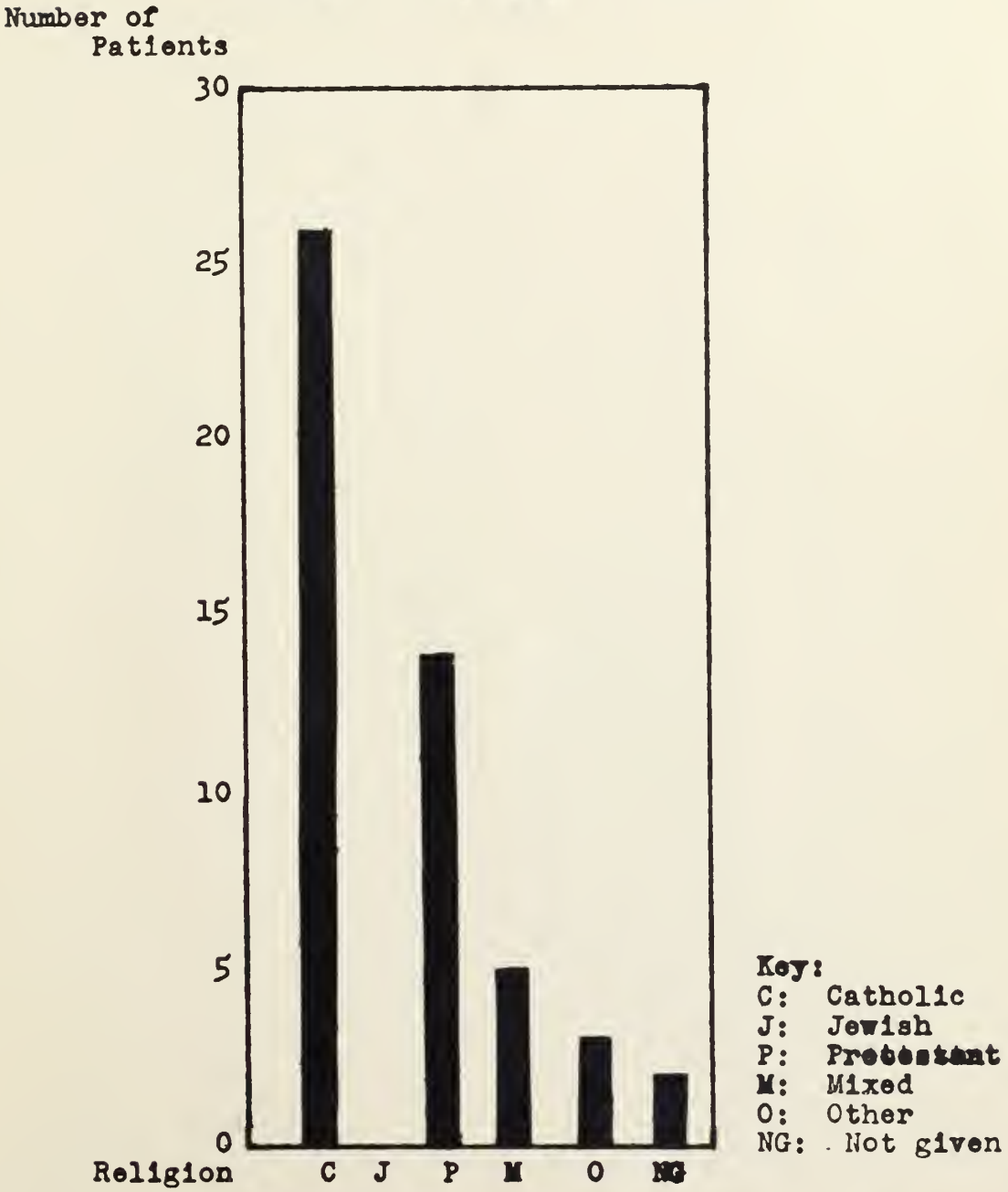


Source: Compiled from patient records on file with the Association, and represents 1 out of 4 antepartal patients served by the 5 Districts

Figure 7

Religious Affiliations of the 50 Antepartal Patients Studied in a Selected Visiting Nurse Association

October 1 - December 31, 1949



Source: Compiled from patient records on file with the Association, and represents 1 out of 4 antepartal patients served by the 5 Districts

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Table 1

Statements Indicative of Factors Which Affect Adjustment in Terms of the Number of Times Recorded for the 50 Antepartal Patients Studied in a Selected Visiting Nurse Association

Presented in groups of Environmental, Interpersonal Relationship, and Personal Factors

October 1 - December 31, 1949

Factors	Number of Times Recorded
Environmental	**48**
Financial difficulty	31
Inadequate housing	17
Interpersonal Relationship	**74**
Contraceptive Advice	13
Difficulty with or inability to handle children	12
Illness in family	10
Inadequate housekeeper	9
Marital discord	8
Domineering mother	6
Parental disapproval	5
Inability to gain patient's confidence	2
Husband objecting to medical care for wife	2
Resentful of husband	2
Fear of husband	1
Homesick, husband away	1
Husband deserted	1
Immaturity of husband	1
Religious differences	1
Personal	**164**
General physical complaints	25
Neglect of health, not following orders	18
Unhappiness with pregnancy	16
Anxiousness, nervousness and fidgetiness	15
Nausea and vomiting	13
Fear of pregnancy and delivery	12
Past abortions and stillbirths	11
Abdominal cramps	10
Oversolicitude of self	7
Fear of losing baby	7
Happiness with pregnancy	6
Past psychiatric illness	4
Fear of heredity	3
Fear of marking baby	3
Threatened abortion	3
Immaturity	2
Question of epilepsy (later proved psychosomatic)	2
Rh negative	2
Attempted abortion	1
Fear of inadequacy	1
Feelings of "choking"	1
Negro Inferiority	1
No preparation for baby	1

main categories: environmental, interpersonal relationship, and personal factors. The two environmental factors occur with the greatest frequency; the financial problem being in first place, and inadequate housing, fourth. The fifteen interpersonal factors are mentioned a total of 74 times. Of these, the relationship with the husband is noted 17 times; and the relationship with other members of the family, 33 times. Two other factors which might affect successful relationships are recorded 22 times. The type of nurse-patient relationship is recorded only twice; in both instances, the nurse felt she was unable to gain the patient's confidence. This was later discussed with the two nurses involved. One felt that the patient was afraid of something and hoped to work that out with the patient; she planned to make more frequent visits. The other nurse felt the patient was immature and not interested either in the pregnancy or in the assistance the nurse would be able to give. She stated that this lack of interest seemed common to quite a number of antepartal patients.

The twenty-three personal factors were tabulated for a total of 164 times. Of these, in second and third place in rank order, are the health problems indicated by numerous physical complaints, and neglect of health and not following orders. The complaints were as follows: constant headache, constipation, tiredness, anorexia, excessive weight gain or loss, diarrhea, cramps in legs, and symptoms of toxemia. Nausea and vomiting were not noted unless these symptoms occurred at such specified times as at the diagnosis of

pregnancy, a report indicating greater severity than "usually expected", and the continuation beyond the third month. Of those patients complaining of persistent abdominal cramps, three were diagnosed as threatening abortion, and one had made an unsuccessful attempt at abortion. Of the eleven who had experiences of past abortions and stillbirths, only two are Rh negative.

Expressed unhappiness with the pregnancy stands fifth on the list. Sixteen patients gave reasons for objecting to the pregnancy. Table 2 may be used to show the number of times patients gave the same reasons for objecting to the pregnancy. There is a disparity between the number of patients and total number of reasons, as some gave more than one reason. Although unhappiness with the pregnancy is noted only 16 times, happiness with the pregnancy is noted only 6 times. This accounts for 22 of the 50 patients. With regard to the other 28, was the attitude toward the pregnancy not noted by the nurse because it was not specifically mentioned by the patient? From subsequent discussion with the nurses, it was apparent that they had not specifically attempted to identify whether the patients were happy or unhappy. Thus, it might be inferred that the nurses failed to consider this as a significant factor in determining patient needs.

Fifteen patients are described as being nervous, anxious, and fidgety. At times these were the specific expressions of the patients, other times, of the nurse. The records show two of these had a previous mental illness; for the rest, no mention

Table 2

Reasons for Unhappiness with Pregnancy
as Stated by 16 Antepartal Patients
in Terms of Number of Times Specified

Reason for Objecting to Pregnancy	Number of Times Specified
Too frequent pregnancies	8
Financial difficulty	7
Fear of resulting illness from pregnancy and delivery	5
Fear of losing husband's affection	1
Forced marriage	1

Source: Compiled from the records of 50 Antepartal Patients Studied in a Selected Visiting Nurse Association, October 1 - December 31, 1949.

was made if these symptoms existed before the pregnancy. Two others have a history of mental illness; and two are diagnosed as having functional epilepsy, one of these experiences "choking feelings". Another is described as being immature. Twenty-six incidences of fear directly related to the pregnancy are recorded. As has been pointed out by the experts in the field, the state of tension, anxiety, and fear reactions may be premonitory signs of mental illness. The nurse should be alerted to and report, early, these manifestations. For with guidance, the patient may be aided to a more satisfactory and comfortable adjustment by alleviation of these stress symptoms.

The factors involving emotional adjustment were also tabulated according to gravida, years of age, and religious affiliation groupings. No one problem was found to be predominant for any grouping. (Table 1 - Appendix).

Of the 50 patients in the study, only one was referred to the mental hygiene consultant. Table 3 may be used to show the six main problems that were referred to the mental hygiene consultant by comparison with the six main problems of the group studied. During 1949-50, of the 99 maternity patients referred to the mental hygiene consultant, 86 were referred during the antepartal period. Moreover, 47 were from the 5 districts studied; one of these is included in this study. From a comparison of the first six problems of the 47 patients referred from the district studied, with the first six problems of all antepartal patients referred, it is interesting to note that the problems remain the same but the rank order changes

Table 3

First 6 Main Problems of Antepartal Patients

1. First 6 Main Problems of the 86 Antepartal Patients Referred to the Mental Hygiene Consultant, in Terms of the Number of Patients Presenting them, 1949-50.

Problem Presented	Number of Patients
Depressed, discouraged, upset mentally	29
Rejection of pregnancy	12
Illegitimate pregnancy	10
Marital discord	7
Psychiatric illness, previous or present care	6
Attitude of husband	6

2. First 6 Main Problems of the 45 Antepartal Patients Who Were Referred to the Mental Hygiene Consultant from the 5 Districts Studied, in Terms of the Number of Patients Presenting them, 1949-50.

Problem Presented	Number of Patients
Depressed, discouraged, upset mentally	17
Illegitimate pregnancy	6
Psychiatric illness, previous or present care	5
Attitude of husband	4
Rejection of pregnancy	3
Marital discord	3

3. First 6 Main Problems of the 50 Antepartal Patients Not Referred to the Mental Hygiene Consultant,* Who Were Included in this study, in Terms of the Number of Patients Presenting them, October 1 - December 31, 1949.

Problem Presented	Number of Patients
Financial Difficulty	31
General physical complaints	25
Neglect of health, not following orders	18
Inadequate housing	17
Unhappiness with pregnancy	16
Nervousness, anxiousness, fidgetiness	15

*Only one patient in this group was referred.

Source: Compiled from the Mental Hygiene Consultant's records and from 50 patient records on file with the Association.

with all except the first problem. By a comparison of the first six problems of the group studied with the first six problems of the patients from the same districts, who were referred to the mental hygiene consultant, it is noted that only two problems remain the same. There were no cases of illegitimate pregnancy among the patients in the study. The sixth problem of the group studied is the first problem in rank order of those referred to the mental hygiene consultant, but in this instance apparently the "nervousness" and "anxiousness" were not considered severe enough to warrant consultation. Again, the fifth problem of unhappiness with pregnancy is apparently not considered a severe enough difficulty to refer, although the rejection of the pregnancy had been expressed verbally. When these were discussed with the nurses, they felt that in all these instances they were successfully handling these problems and did not need help. Obviously, these data are not sufficiently discreet to show why some patients are referred while others are not.

What the interviews with the field service nurses revealed

It now becomes important to see what the nurses, in a given Agency, actually do and how they feel about the emotional problems of maternity patients. For the purposes of this study, it was derived that interviews with one out of ten staff nurses would yield a reasonably reliable overview of the staff nurses as a whole. Therefore, ten nurses, selected by the Agency as being a cross-section of the total group, were interviewed.

They had the following characteristics:

1. Seven were reported to have the ability to recognize and handle emotional problems.

2. Four of the ten are in charge of the Mothers' Clubs in their respective districts.

3. They have been employed by the Agency as follows:
   a. One for twenty-five years
   b. One for twelve years
   c. Three for three years
   d. Two for two years
   e. Three for less than a year

4. They have had psychiatric training as follows:
   a. One, no preparation
   b. Nine, 2-4 months as a part of their basic nursing preparation.

5. One has had an advanced course in obstetrical nursing.

6. They graduated from schools of nursing as follows:
   a. Seven from schools located in or near this area
   b. Three from schools located outside of the state.

Six of the ten nurses were interviewed by presenting them with a list of the problems selected from the records and asking them to check:

1. The problems which stemmed from the emotions
2. The problems which had an affect upon the emotions

and to tell how they would deal with each problem. Each one felt that the following affect the emotions:

1. Fear of husband
2. Financial Difficulty
3. Inadequate housing
4. Rh negative.

Each one indicated that the following are entirely emotional in nature:

1. Immaturity
2. Inability to gain patient's confidence
3. Nervousness, anxiousness, fidgetiness.

Each one had an opportunity of checking the problems which are affected by or affect the emotions.

A. The following conditions affecting the emotions were checked at least 3 times more than the others:

1. Domineering mother
2. Husband objecting to medical care for wife
3. Illness in family
4. Numerous physical complaints
5. Parental disapproval
6. Religious differences

B. The following conditions affected by the emotions were checked at least 3 times more than the others:

1. Difficulty with or inability to handle children
2. Fear of heredity
3. Fear of inadequacy
4. Fear of losing baby
5. Fear of marking
6. Fear of pregnancy and delivery
7. Feelings of "choking"
8. Inadequate housekeeper
9. Marital discord
10. Neglect of health, not following orders
11. Oversolicitousness of self
12. Unhappiness with pregnancy

C. The following conditions were evenly balanced or checked with a difference no greater than two:

1. Abdominal cramps
2. Attempted abortion
3. Contraceptive advice
4. Happiness with pregnancy
5. Homesickness, husband away
6. Immaturity of husband
7. Nausea and vomiting
8. Negro inferiority
9. No preparation for baby
10. Past abortions and stillbirths
11. Question of epilepsy (later proved psychosomatic)

All checked that they would attempt to meet and handle these problems first, by finding what conditions existed, second, by trying to work through the problem with the family, and last,

only when necessary, by referring the family to the best source for help. The more serious problems of financial difficulty, inadequate housing, and marital discord would be referred to a social agency. To the mental hygiene consultant would be referred those more serious problems in:

1. Attempted abortion
2. Difficulty with and inability to handle children
3. Fear of pregnancy and delivery
4. Inability to gain patient's confidence
5. Inadequate housekeeper
6. Parental disapproval
7. Past psychiatric illness
8. Unhappiness with pregnancy.

The remaining problems, if no progress were apparent through education and discussion, would be referred to the doctor, spiritual adviser, social worker, or mental hygiene consultant for direct guidance of the patient or for guidance of the nurse in handling the situations. Each one stressed that the physical complaints and symptoms should be discussed with the doctor. All of this group mentioned the nurse's attitude as being important, that she should not judge, but have an open mind and be tolerant. She should listen to what the patient says and try to understand what and how she feels. And that, above all, the nurse must have enough knowledge about the maternity cycle and related subjects to be secure on the visit.

Four of the ten nurses were interviewed by asking them:

1. What they considered emotional problems
2. What problems affected the emotions
3. How they would handle these problems.

The problems they considered emotional in nature are:

1. Fears
2. Nervousness, anxiousness, fidgetiness

3. Neglect of health, not following orders
4. No preparation for baby
5. Some physical complaints as nausea and vomiting.

Those conditions which affect the emotions are:

1. Housing conditions
2. Illness in family
3. Marital discord
4. Parental disapproval
5. Physical symptoms
6. Unhappiness with pregnancy.

All four felt that the nurse could handle those problems in which talking out, feeling out, and clarifying the situation would help the patient to see what needed to be done; such as, those problems of fear of labor and delivery, and fear of losing the baby due to past abortions and stillbirths (reality situations). They would handle these emotional problems by:

1. Helping the patient to see that she needs help, by feeling out the problem.

2. Giving the patient a knowledge of what is happening during the pregnancy, stressing the normalcy of the condition.

3. Making known to the patient those agencies available for assistance.

4. Visiting more frequently to give encouragement.

5. Showing interest in the patient as a person.

6. Listening to the patient to find out "why the patient is doing this, saying this, having this reaction; is she justified?", but, at the same time, not judging.

Patients with the following problems would be referred to a social agency:

1. Absconded husband
2. Financial difficulty
3. Illegitimate pregnancies
4. Marital difficulty.

To the mental hygiene consultant, patients with the following problems would be referred:

1. Any with which no progress seems evident. The nurse needs to discuss this kind of case for clarification and aid in the kind of approach to be used.

2. Any that are not mitigated by airing and in which it is evident that the problems are deep-seated in the emotions.

Of the ten interviewed, three expressed a desire for a "1-2-3 advice" to be given by the mental hygiene consultant to aid the nurse to handle situations and family problems. Eight wished more conferences with the consultant to aid them in clarifying progress, in following through work done, and for pointing up problems which might be overlooked.

It is evident that all the nurses interviewed are fairly consistent as to what problems are emotional in nature, what problems affect the emotions, and how they would handle these problems. Only four mentioned specifically the need for establishing a good working relationship with the patient, although all mentioned several elements necessary for establishment of rapport. Only one specified the need of the nurse to understand how she relates and reacts to the patient and situations, and expressed a desire to work on this with the mental hygiene consultant. Only four specifically commented on the importance of the woman's attitude toward the pregnancy and the subsequent reactions on the kinds of emotional problems and symptoms presented. Emphasis was laid on didactic teaching, stressing the normalcy of the condition and the importance of good obstetrical care. There is a lack of emphasis on the importance of

the husband, his education, and his part in aiding his wife adjust to the pregnancy.

What the comparison of aspects recorded, recognized and handled is to what the authorities say

As previously noted from the review of the literature and the personal interviews with psychiatrists and obstetricians, there are many factors which should be recognized and dealt with in aiding the expectant woman to adjust to her pregnancy with the maximum possible physical and mental health. Although much of this material is not specifically directed toward the role of the nurse in recognizing and meeting the emotional needs of the patient, it is quite evident that the factors mentioned must be taken into consideration by any good nurse. In the materials presented that do stress the role of the nurse, it can be noted that the nurse needs to have knowledge and skill in dealing with the psychological as well as the technical aspects of obstetrics.

Specifically, the emotional aspects, which authorities in the field emphasize should be recognized and dealt with, are the adjustment and reactions displayed toward the environment, the pregnancy, and the type of physical symptoms produced. The environment includes the socio-economic factors as well as the relationships with the husband and other members of the family, and the number of previous pregnancies. The economic factors by themselves may not be disturbing, but in combination with other stresses may add an additional burden to the adjustment of the expectant mother.

The attitude of the husband and his relationship to the wife are particularly important during this period. The need for education of the husband and wife, as well as other members of the family, to the physical and emotional changes that occur during the antepartal period is of consequence. These points are reiterated fourteen times by the obstetricians, seventeen times by the psychiatrists, and four times by the nurse educators. The nurses seem quite aware of the economic factors as depicted by the recognition of financial difficulty 31 times, inadequate housing 17 times, and by the fact that both these were mentioned as affecting the emotional reaction. However, the relationship with the husband is mentioned only 17 times, but relationships with others of the family are mentioned 33 times. Thirteen asked for contraceptive advice. When these points were discussed with the nurses, it was apparent that no specific attempt was made to discover the kind of relationship existing between husband and wife or between other members of the family. The nurses felt this topic should be first broached by the patient.

That physical complaints should be carefully noted since many are the result of tension, fear, and anxiety, is propounded by the obstetricians four times, by the psychiatrists eight times, and by nurse educators six times. It can be seen that physical complaints and symptoms are the largest item of recorded factors, since they were mentioned 51 times. All the nurses stressed that these symptoms should be discussed with the doctor. It is interesting to note that numerous physical

complaints are said to affect the emotions, while only a few of the more specific symptoms, such as nausea and vomiting, were accrued any emotional aspects. That the emotional response to the environment and the pregnancy should be observed is specified eight times by the obstetricians, sixteen times by the psychiatrists, and six times by the nurse educators. The nurses have recorded 27 incidences of fears, which are usually phobic in nature, and 15 times the state of anxiety. With the fears and state of anxiety the nurses felt that they were aiding the patient to successfully adjust and handle these. The attitude toward the pregnancy was discussed as previously reported.

It is obvious that the nurses report and discuss all physical symptoms with the doctor, but none of the psychological manifestations. These would be discussed with the doctor, social worker, or mental hygiene consultant only if the nurse felt she were not able to handle and meet the situation after trying to work it through with the patient. When this was discussed, the nurses said they had reported some of the emotional problems to the doctor and the clinic, but the physical complaints only were given recognition. As was previously reported, the clinic doctors particularly stressed the fact that they were so busy they expected the nurse to handle emotional problems and, if she could not, to refer the patient to appropriate sources for guidance. It is evident that the full significance of the early reporting of fears, tensions, and anxieties is not recognized. That these are some of the

symptoms of emotional disturbances which must be allayed or mental illness of a catastrophic nature might become manifest is not given due consideration. Although all of the emotional disturbances may not lead to mental illness, unless they are alleviated the antepartal period may become more uncomfortable than is necessary.

In general, in comparing what the nurse recognizes with what authorities say should be observed, it is evident that there are several areas which need strengthening on the part of the nurse. These are recognition of the:

1. Patient's attitude toward the pregnancy, particularly the negative and ambivalent feelings, as well as the positive ones.
2. Patient's relationship with the husband.
3. Need for establishment of a good working relationship with the patient.
4. Early symptoms of mental illness and emotional disturbances.
5. Interplay of the emotions with the body producing physical symptoms.

However, the nurse has recognized these points not mentioned by the authorities, the relationship with the children, which stands eighth on the list in frequency, and inadequacy as housekeeper, eleventh. Both of these factors add tremendously to the burden of adjustment.

On the whole, there seems to be an avoidance of any discussion relating to the more subtle but more important (psychiatric) emotionally laden problems. The nurse is in a precarious position, since she is expected to handle these emotional problems yet she has had no particular preparation

for this. She is not always given the guidance needed, nor does she always take advantage of available opportunities.

CHAPTER IV

SUMMARY, CONCLUSIONS AND PROPOSALS

In this chapter, a summary will be made, the conclusions will be drawn, and, in view of these, proposals will be offered to aid the nurse to strengthen her abilities to become more adept in recognizing and in meeting the emotional needs of pregnant women.

The findings in the study indicate the profound importance of incorporating the emotional aspects into the care given during the antepartal period. There are variables in the extent to which experts in the fields of psychiatry, obstetrics, and nursing consider the handling of problems concerned with emotional difficulties and maladjustment to be the function of the nurse.

Sensitivity to all signs and symptoms which may be premonitory or specific manifestations of emotional disturbances were seen to be a definite responsibility of the nurses in the situation studied. All of the patients studied were under the medical care of the obstetricians at the clinic. These obstetricians admittedly had time to give primarily to the physical needs of patients during the antepartal period, relying entirely upon the nurses from the Agency to discover and cope with the emotional aspects of care. The policies established by the Agency set the limits of the types of emotional problems which

could be the responsibility of the nurse to deal with herself and identified those which must be referred to another type of worker, namely, the nutritionist, the social worker, or the mental hygiene consultant.

Other factors prevail which, by themselves, may not be disturbing, but, in combination, may exacerbate emotional problems to such an extent that an additional burden is added, straining the adjustment of the expectant mother. Although these emotional disturbances during the antepartal period may not lead to mental illness, unless the family is successfully aided to meet these problems, this period may become more uncomfortable than is necessary. The nurse has a definite role to play with these psychological aspects by recognizing the problems; by aiding the patient through a free expression of feelings to recognize and meet the problems; and by referring the family early for more qualified assistance. For this it becomes evident that the nurse needs preparation and skill in dealing with psychological aspects. However, it must be recognized that nurses have varying degrees of insights into emotional problems.

What the conclusions are

Although exploration of what is being done in the 5 district offices of the Agency indicates that the nurses have an appreciation of the importance of the emotional aspects of care, there is evidence that consideration needs to be given to further strengthening several areas of antepartal care:

1. Increased sensitivity to the expectant mother's attitude toward the pregnancy, the subsequent reactions on the kinds of problems and symptoms, and the understanding of the underlying dynamics. In analyzing the records, it was found that happiness or unhappiness with the pregnancy was mentioned for only 22 of the 50 patients and that, of the 22, only 6 were reported as happy. Happiness with the pregnancy may be as significant an indication of positive adjustment as unhappiness is of emotional maladjustment. Expressed unhappiness may be the clue to some other deeper disturbance.

2. Greater consideration of the psychological aspects of physical manifestations which may be indicative of emotional unrest. It was noted that numerous physical complaints are considered by the nurses to be factors which affect the emotional reaction; whereas the obstetricians and psychiatrists were shown to consider many of the physical symptoms to be the result of tension and anxiety.

3. More clear-cut understanding of what constitutes emotional aspects. It is apparent that some nurses recognize only strong deviations from normal behavior as emotional factors and fail to recognize the implications of the problems presented.

4. More stress on the importance of the husband, his education, his part in aiding his wife adjust to the pregnancy, and his relationship with his wife. It can be seen that the relationship with the husband is mentioned only 17 times and that no specific attempts were made to determine the kind of relationship existing between the husband and wife. There is no

provision for the education of the husband.

5. Deeper appreciation of the need for establishing a good working relationship with a patient; skill in establishing rapport abetted by the nurse's understanding of how she relates to patients and reacts to situations. Understanding and skill in the use of nondirective technics of interview and less emphasis on didactic teaching, for unless emotional needs are met and good rapport established, all teaching falls on sterile ground. The study revealed, and this is corroborated by the authorities in the field, that more emphasis is laid on didactic teaching as the means of alleviation of emotional stress rather than on nondirective technics which allow the patient free expression of feelings. It was also noted that many of the nurses interviewed, as well as the obstetrical nursing texts, rely on such didactic teaching. The values resulting from a clear-cut exposition of the natural phenomena of pregnancy are not minimized, but attention needs to be given to the ways patients really react emotionally and how they feel about conditions arising during pregnancy.

What the proposals are

It is apparent that some modifications are needed if the quality of care desired by the Agency is to be consistently attained. There are, however, certain factors which must be taken into consideration in any proposals presented. The antepartal service is only one segment of the care given by the Agency, thus the time given in in-service education to the emotional aspects of pregnancy cannot be done at the neglect

of the other aspects. However, it would seem that the most opportune time for emphasis on the recognition of the emotional problems and aspects of care is in the antepartal period where the foundations of life are laid. Moreover, the attitudes of the parents during pregnancy influence the kind of parent-child relationship formed later, and the kind of interpersonal relationship established fosters mental health or illness. During the antepartal period, the nurse enters many homes she would not ordinarily be in for health supervision. Thus, the nurse is in a strategic position to offer aid in the solution of emotional difficulties. It becomes imperative, then, that the Agency recognize that emotional problems, as well as the physical, are the responsibility of the nurse; and that the Agency make every attempt to aid the nurse meet this responsibility by not so pressing her with so many difficult nursing cares that she is unable to think about and aid the patient meet these emotional problems. Emphasis needs to be placed upon the emotional aspects of nursing. As in the antepartal period, many of the common experiences and frustrations of everyday life may be exacerbated, thus straining adjustment.

A nurse, upon graduation, is neither a finished product nor an expert in any field; her education is a continuous process. An in-service program is an invaluable tool for aiding the nurse to be of more service to the community and to continue her own professional growth. The Agency sponsors an in-service program in which the planning is primarily the responsibility of the staff nurses and is geared to their needs.

Moreover, the consideration of the patient as a person in relation to his family and in his home is stressed as the basis of the nursing care given. To carry out this aim, it is essential that it be recognized that good nursing care is dependent upon the establishment of good interpersonal relationships and the concomitant realization that patients are always human beings, each with his own distinctive personality. Again, skill in the technical aspects of nursing is not being minimized, but the nurse needs both; otherwise, other prepared persons such as social workers could be utilized.

Following are the proposals:

1. For the orientation period -

A definite concentration be placed on the importance of recognizing, recording, and meeting the emotional problems involved in all conditions and particularly those of the antepartal period. Perhaps a pretest for attitudes about emotional aspects of care could be devised on a situational basis, which would enable the Agency to determine where the mental hygiene consultant would need to place emphasis. Definite appointments for each new nurse with the mental hygiene consultant would be of value in establishing a working relationship early between these workers, and in clarifying the role of the consultant. On home visits during the first three months, the consultant could evaluate actual skill of the nurse through these early periods of supervision. Inasmuch as each nurse varies in ability to recognize and meet emotional problems, and in the amount of guidance needed, a periodic review of patient records,

as well as further home visits, would enable the mental hygiene consultant to see how the nurse is progressing. Since giving care in the home is usually a completely new experience for the nurse, one of the orientation lectures could well be spent on the technics of interviewing and counseling, stressing the non-directive methods. Role-playing, utilized to demonstrate points both in the interviewing technics and in methods of approaching emotional problems, would form a frame of reference upon which the nurse could base her activities and reactions. Consciously directed thinking and observations for emotional aspects and difficulties do not necessarily increase the time spent on a visit. In the long run, through early recognition and reporting of emotional problems, much greater benefits will be reaped in the prevention of more severe periods of stress and of mental illness. The nurses will need guidance to develop skill in approaching and in getting the patient to recognize and to be willing to cope with existent problems and to want more expert help when required.

2. For the in-service program -

Good nursing has always included recognition and handling of the emotional aspects. However, it has only been in the last few years that thinking has been directed consciously toward that end. Finally these psychological aspects of nursing were named. But naming is not enough. With the tension and unrest resulting from the socio-economic conditions in a rapidly changing world, more and more stress needs to be placed upon these emotional aspects of care. The nurse needs to be

constantly re-evaluating herself and her relation to these aspects. She needs to develop skill in recognizing and dealing with them. Therefore, it is suggested that at every opportunity these emotional aspects be considered and discussed. One of the large staff meetings could be devoted to the psychological aspects of nursing. Under the direction of the mental hygiene consultant, the emotional aspects of all topics under discussion in the districts could be considered. The effects of socio-economic conditions on the emotional and psychosomatic reactions need to be stressed. Reference materials and annotated bibliographies would aid the nurse increase her professional growth. The nurse needs to realize education is a continuous process that is never ended.

Periodic patient studies, especially of antepartal patients, guided by the mental hygiene consultant, would aid in clarifying emotional aspects and problems. Role-playing could again be utilized to aid the nurse increase her ability to recognize and meet emotional problems and to more successfully aid the patient make a satisfactory adjustment.

It is also suggested that the mental hygiene consultant conduct an hour group discussion once a month in each district. These discussions should be nurse-problem centered with stress on the "whys" involved in the development of good interpersonal relationships. The spending of the hour on group discussion in each district each month is the only major change in the use of time. This will justify itself by the insight the nurse gains into her own self and her relations to patients and

reactions to situations; the insight the nurse gains into emotional aspects; and the consequent improvement in family health service.

3. For the Agency policies and actions -

It has been noted that the doctors in the clinic admittedly disregard the emotional aspects of pregnancy. Therefore, if the Agency takes the initiative in establishing conferences between the obstetricians, mental hygiene consultant, and the nurses of both the Association and the hospital, the importance of the recognition and meeting of these emotional aspects and the roles of the doctor and the nurses in relation to these, might be further emphasized and clarified. Through this intercooperation, increased referral and interest should result. It would seem feasible to start these conferences in an area where success is most likely to be guaranteed. If these conferences can be shown to be effective with one group, it would seem reasonable to expect that other areas would also become interested. Even if this program does not attain a large scale of cooperation, the efforts in one area will pay dividends in the comfort the expectant mother can be aided to attain, in the satisfaction that comes from group cooperation, and in the increased skill the nurses will have developed.

As has been pointed out in the literature reviewed, husbands need to be included in antepartal teachings. It would seem advisable to suggest that some arrangements be made for combined classes for husbands and wives. The Association, the Red Cross, and other agencies involved could offer such courses

to the community at a time that most of these people can be reached. Such cooperation in planning would save duplication of efforts as well as reach a larger proportion of expectant mothers and fathers.

What the suggestions for further study are

This study attempts to show what the nurses in a given agency recognize as emotional problems and how these are handled, in comparison to what authorities in the field feel should be recognized and handled. Using this study as a basic frame of reference, two further studies can be suggested. A series of case studies of patients and of nurses in the actual situation might reveal other areas in need of improvement, as well as identify those nurses who have particularly deep insight for handling emotional problems. The public health nursing agencies have a responsibility for interpreting to the schools of nursing what is required of their field nurses. A study of what is required of their nurses who care for pregnant women and what the nurse needs to be capable of meeting the maternity patient's needs, might reveal many suggestions for the basic preparation of nurses in the obstetrical nursing area.

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APPENDIX

TABLE 1 - APPENDIX

Emotional Problems Recorded for 50 Antepartal Patients
Presented in Terms of Gravida, Years of Age and Major Religious Affiliations
October 1 - December 31, 1949

TYPE OF PROBLEM RECORDED	NUMBER OF TIMES RECORDED FOR EACH CLASSIFICATION																						
	GRAVIDA										YEARS OF AGE							RELIGION					
Total Number in each:	1	2	3	4	5	6	7	8	9	Total	16-20	21-25	26-30	31-35	36-40	41+	Total	C	P	M	O	NG	Total
	14	8	10	4	1	5	5	2	1	50	7	16	13	8	5	1	50	26	14	5	3	2	50
Environmental Factors	13	6	5	3	2	7	7	3	2	48	8	14	11	10	4	1	48	23	14	5	4	2	48
Financial difficulty	9	3	4	2	1	5	4	2	1	31	5	9	7	6	3	1	31	15	9	3	2	2	31
Inadequate housing	4	3	1	1	1	2	3	1	1	17	3	5	4	4	1	-	17	8	5	2	2	-	17
Interpersonal Relationship Factors	19	10	10	5	1	7	13	6	4	74	13	19	18	11	9	4	74	39	21	7	7	-	74
Contraceptive advice	3	3	1	-	-	2	3	-	1	13	1	5	2	1	4	-	13	4	7	-	2	-	13
Difficulty with or inability to handle children	-	3	3	1	-	1	2	1	1	12	1	1	5	3	2	-	12	6	4	1	1	-	12
Illness in family	1	1	2	1	-	2	2	1	-	10	1	4	1	3	-	1	10	5	3	1	1	-	10
Inadequate housekeeper	2	-	1	-	1	1	2	1	1	9	2	2	2	2	1	-	9	5	2	1	1	-	9
Marital discord	2	1	-	2	-	1	1	1	-	8	1	1	4	1	-	1	8	5	2	1	-	-	8
Domineering mother	3	-	1	-	-	-	1	1	-	6	3	1	1	-	1	-	6	4	1	-	1	-	6
Parental disapproval	3	1	1	-	-	-	-	-	-	5	2	1	1	-	1	-	5	3	-	1	1	-	5
Inability to gain patient's confidence	1	-	-	1	-	-	-	-	-	2	-	1	1	-	-	-	2	2	-	-	-	-	2
Husband objecting to medical care for wife	-	-	-	-	-	-	1	1	-	2	-	-	-	1	-	1	2	1	1	-	-	-	2
Resentful of husband	2	-	-	-	-	-	-	-	-	2	1	1	-	-	-	-	2	1	-	1	-	-	2
Fear of husband	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	1	1	-	1	-	-	-	1
Homesick, husband away	-	1	-	-	-	-	-	-	-	1	-	1	-	-	-	-	1	1	-	-	-	-	1
Husband deserted	1	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	1	1	-	-	-	-	1
Immaturity of husband	-	-	1	-	-	-	-	-	-	1	-	-	1	-	-	-	1	1	-	-	-	-	1
Religious differences	1	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-	1	-	-	1	-	-	1
Personal Factors	38	23	39	14	6	21	11	11	1	164	22	46	50	26	18	2	164	82	45	16	15	6	164
General physical complaints	5	7	6	2	1	4	-	-	-	25	5	5	8	3	4	-	25	15	7	1	1	1	25
Neglect of health, not following orders	2	3	3	3	-	4	2	-	1	18	1	4	6	3	3	1	18	8	5	3	2	-	18
Unhappiness with pregnancy	5	2	1	1	1	3	3	-	-	16	3	7	4	2	-	-	16	6	5	1	3	1	16
Anxiousness, nervousness, fidgetiness	2	1	4	2	-	2	2	2	-	15	-	5	5	4	1	-	15	9	3	2	1	-	15
Nausea and vomiting	2	2	3	1	-	2	1	2	-	13	3	5	4	-	-	1	13	5	5	2	1	-	13
Fear of pregnancy and delivery	5	1	3	-	-	2	-	1	-	12	3	3	4	1	1	-	12	10	1	1	-	-	12
Past abortions and stillbirths	-	1	2	1	1	3	1	2	-	11	-	1	4	5	1	-	11	7	1	2	1	-	11
Abdominal cramps	1	1	4	1	2	-	1	-	-	10	1	3	2	3	1	-	10	2	5	1	1	1	10
Oversolicitude of self	4	1	2	-	-	-	-	-	-	7	2	2	2	-	1	-	7	3	2	-	1	1	7
Fear of losing baby	-	1	4	1	-	-	-	1	-	7	-	1	3	1	2	-	7	5	-	-	1	1	7
Happiness with pregnancy	4	1	1	-	-	-	-	-	-	6	2	3	1	-	-	-	6	4	2	-	-	-	6
Past psychiatric illness	2	1	-	-	-	-	1	-	-	4	-	2	1	-	1	-	4	2	1	-	1	-	4
Fear of heredity	1	-	1	-	-	1	-	-	-	3	-	1	2	-	-	-	3	2	-	1	-	-	3
Fear of marking baby	1	1	-	-	-	-	-	1	-	3	-	2	-	1	-	-	3	1	1	1	-	-	3
Threatened abortion	-	1	-	1	-	-	-	1	-	3	-	-	1	1	1	-	3	-	2	1	-	-	3
Immaturity	2	-	-	-	-	-	-	-	-	2	1	1	-	-	-	-	2	-	1	-	-	1	2
Question of epilepsy	-	-	2	-	-	-	-	-	-	2	-	-	1	-	1	-	2	-	2	-	-	-	2
Rh negative	-	-	-	-	1	-	-	1	-	2	-	-	-	1	1	-	2	1	-	-	1	-	2
Attempted abortion	-	-	1	-	-	-	-	-	-	1	-	-	1	-	-	-	1	-	-	-	1	-	1
Fear of inadequacy	-	-	-	1	-	-	-	-	-	1	-	-	-	1	-	-	1	-	1	-	-	-	1
Feelings of "choking"	-	-	1	-	-	-	-	-	-	1	-	-	1	-	-	-	1	1	-	-	-	-	1
Negro inferiority	1	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-	1	-	1	-	-	-	1
No preparation for baby	1	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	1	1	-	-	-	-	1

Source: Compiled from records on file with the Agency, and represents 1 out of 4 Antepartal Patients served by the 5 district offices.

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